UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

CRISTAL DUNKERSON, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C03-3002-MWB **REPORT AND RECOMMENDATION**

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I. INTRODUCTION

The plaintiff Cristal Dunkerson ("Dunkerson") appeals a decision by an administrative law judge ("ALJ") denying her applications for Title XVI supplemental security income ("SSI") and Title II disability insurance ("DI") benefits. Dunkerson argues the Record does not contain substantial evidence to support the ALJ's decision. Specifically, she argues the ALJ erred in failing to evaluate Dunkerson's credibility under proper standards, failing to include in his assessment of Dunkerson's residual functional capacity all of the limitations supported by the medical evidence, and presenting an improper hypothetical question to the Vocational Expert. (*See* Doc. No. 13)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On October 16, 2002, Dunkerson protectively filed applications for DI and SSI benefits, alleging a disability onset date of May 17, 2000. (R. 109-11, 399-401A; *see* R. 27) The applications were denied initially on April 10, 2001 (R. 95, 97-100, 402), and on reconsideration on August 21, 2001 (R. 96, 103-07, 403). On October 22, 2001, Dunkerson requested a hearing (R. 108), and a hearing was held before ALJ John P. Johnson on February 6, 2002, in West Des Moines, Iowa. (R. 33-94) Dunkerson was represented at the hearing by attorney Jean Mauss. Dunkerson testified at the hearing, as did Vocational Expert ("VE") Marion Jacobs.

On August 20, 2002, the ALJ ruled Dunkerson was not entitled to benefits. (R. 10-27) On November 8, 2002, the Appeals Council denied Dunkerson's request for review (R. 5-7), making the ALJ's decision the final decision of the Commissioner.

Dunkerson filed a timely Complaint in this court on January 10, 2003, seeking judicial review of the ALJ's ruling. (Doc. No. 1) In accordance with Administrative

Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Dunkerson's claim. Dunkerson filed a brief supporting her claim on September 2, 2003. (Doc. No. 13) The Commissioner filed a responsive brief on October 28, 2003. (Doc. No. 14).

The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Dunkerson's claim for benefits.

B. Factual Background

1. Introductory facts and Dunkerson's daily activities

At the time of the hearing, Dunkerson was 46 years old. She was 5'5" tall and weighed 208 pounds. She stated she lives in a rented house with her 23-year-old son. (R. 37-38) She has a valid driver's license with no restrictions, and outside of work, she drives about ten miles per week. Her brother drove her to the hearing. (R. 67)

Dunkerson graduated from high school. She stated she was in special education classes all the way through school due to dyslexia, which prevents her from reading and spelling very well. (R. 38-39) According to Dunkerson, testing performed at the time she graduated from high school indicated she had a third-grade reading level. (R. 39) Dunkerson stated she has to read things several times to understand them because she has poor comprehension. (R. 40) She has trouble understanding newspaper articles and has to read them very slowly. (R. 67) She stated she can add and subtract pretty well if she takes her time, but she usually uses a calculator. (*Id.*)

Dunkerson testified regarding her employment history. She worked at Sutter Memorial Hospital from 1984 to 1992. (R. 143) She started out as a housekeeper and "project person," which required her to lift laundry baskets and laundry bags that weighed

about fifty pounds, and a buffer that weighed about 100 pounds. (R. 48, 73, 143) Her earnings dropped in about 1991, when she was injured on the job. She explained:

> I worked as a project person at the hospital at that time where we did moving of the furniture when we relocated different floors, like the Ped's Unit or where we were doing remodeling and stuff. Also, I did stripping and waxing of floors, and we would have to lift the buffer off of a flatbed cart down onto the floor and then back up on the cart. And during that time, I injured my low back. And then, I couldn't go back to that type of work. I couldn't stand up straight for quite some time.

(R. 41)

After she was injured, Dunkerson took some computer classes for five or six months. The classes were for three hours, three times a week, and she learned Windows and MS DOS. (R. 80) After she learned to use a computer, she then did office work part time at the hospital for a few months in 1992, setting up meetings and reservations. She worked twenty hours a week, four hours a day. (R. 69-70, 80-81, 143) She explained the hospital had seven meeting rooms, and she would book meeting reservations for the rooms. She also ordered equipment as required for the meetings. She would receive a hard copy of the reservation information, and she would input the information into a computer. She printed out daily reports regarding scheduled meetings and required equipment. (R. 73-74) She took some phone messages, but stated she often would transpose numbers and make mistakes. (R. 40) Another employee helped her get her work done at times, and also checked her work and caught mistakes Dunkerson had made. Dunkerson did not feel she met her employer's expectations, but she opined the employer made allowances for her because she was in the same department where she had been working before her injury. (R. 81) The reservation job was done primarily sitting down, and required no lifting or carrying. (R. 74)

From 1993 to 1994, Dunkerson worked at McDonald's, in the kitchen. (R. 71, 114, 143, 148) She worked seven hours a day, five days a week, and earned $5.25 per hour. (R. 148; *see* R. 72) She cooked and prepared food, toasted buns, and made sandwiches, all of which required her to stand. (R. 71, 72, 148) On her work history report form, Dunkerson indicated she had to carry boxes of meat from the freezer to the work station once a day. She indicated she sometimes lifted twenty pounds, and she lifted less than ten pounds frequently. (R. 148) In her testimony, Dunkerson stated she "never carried the cases of the patties up," and the most she lifted was ten pounds. (R. 72)

Dunkerson worked at American Home Shield, a home warranty company, from 1994 to 2000. (R. 143, 114-15) She worked eight or more hours a day, five days a week, and earned $7.50 to $8.00 per hour. (R. 144-45) She started as a customer service representative, taking calls from people who were placing orders for work to be done at their homes. She would log the orders into the computer, and then fax them to a company that would do the actual work. She stated she worked much slower than other employees to make sure she got things "in the right order when typing on the computer and stuff because of the fact that they could be used as a legal document if we were ever sued." (R. 40, 45) She stayed in the customer service department for about four years. (R. 68) She then moved to the dispatching department, which she thought would be easier because she would just deal with the technicians and would not have to deal with the homeowners or input the work orders. She only worked as a dispatcher for about six months, and then she began working in the authorization department. (R. 47-48, 68) She described the authorizer's job as follows:

> Technicians would call in and tell us what the problem is to get authorization to do the work, and we would have to decide if it was covered or uncovered. Technicians, most of our technicians know whether it's going to be covered or not

> and then, when they call in, they say, "This isn't going to be covered." And they'll tell you what it is. You have to put it into the computer. And then, if they're still at the home, we have to tell the homeowner that it's not covered. If it's a covered item, they just tell us how much it's going to cost and we give them an authorization number to get paid for it.

(R. 68) Dunkerson stated she worked as an authorizer for about six months, during which time she had trouble with the job and sought help from coworkers. (R. 69)

Dunkerson indicated that although she received good work evaluations at American Home Shield with regard to her ability to deal with people, the evaluators indicated she needed to improve her ability to work at a faster pace. (R. 41) She estimates she worked thirty to fifty percent slower than other employees. (*Id.*) She noted that all three of the jobs she did at American Home Shield were performed sitting down, and they did not involve carrying or lifting. She wore a telephone headset and entered information into a computer. She stated she did "hunt and peck" typing, rather then five-finger typing, and she still watches her hands because she cannot remember where the keys are. (R. 69, 80)

While she was working at American Home Shield, Dunkerson had some part-time, second jobs. She worked as a cashier at Casey's convenience store in 1998 and 1999. She worked five hours a day, two or three days a week, and earned $5.25 per hour. (R. 115, 143, 145) The job involved some stocking of the refrigerator, requiring her to lift crates of pop and beer that weighed about thirty pounds. (R. 47, 70) She stated the lifting and standing required in the job caused her to suffer a hip injury, where her hip would go "out of place." (R. 47) She explained she initially had no trouble running the cash register, but she had more problems when she began to experience stiffness and numbness in her hands. Also, she occasionally had trouble making change, and customers would point out the error. The manager balanced the register, and according to Dunkerson, the manager

never said anything to her about running short or long on her cash at the end of the day. (R. 48) She did not do any type of written reports as part of the Casey's job. (R. 70)

She also worked at Payless Shoes in 1994, 1995, 1997, and 1998, earning $10.00 per hour. She worked four to five hours a day, four to five days a week. (R. 113-15, 143, 147) She waited on customers, checked customers out at the cash register, received shipments of shoes and stocked shelves, and cleaned up the store. (R. 147) The job required her to stand most of the time, and she noted she was "constantly moving, too, because we had to bring the shoes down off the shelves and fill and clean shoes." (R. 70) However, she only had to lift one box of shoes at a time, which she estimated might weigh about five pounds. (R. 70-71) She did reconcile the register at Payless, which she noted was done on a computer. (R. 71)

Dunkerson stated she left American Home Shield because she became depressed and suicidal after her mother died, and her doctor told her not to work. She stated, "I was suicidal, wanted to die, wanted to take my son with me." (R. 46) She also was having trouble with her back, and with numbness in her arms. She stated testing revealed that her carpal tunnel syndrome had worsened quite a bit. (*Id.*)

According to Dunkerson, she also was having migraines almost daily at the time she quit working for American Home Shield. She indicated the headaches began while she was still working at the company. She would not leave work because she did not have sick leave, but sometimes she would go into the infirmary and lie down, or put her head down on her desk. (R. 74) She stated she woke up with headaches in the morning and went to bed with them at night. She stated she still has trouble with occasional migraines, but they are much better than they were at the time she quit the American Home Shield job. She noted the migraines still occur once or twice a month, depending on her stress level. (R. 46-47)

At the time of the hearing, Dunkerson was working part-time as a cab driver, for $5.00 per hour. She started the job in February or March of 2001. She stated she usually works two to three days a week for about two hours a day. She sometimes works three hours in a day when her boss has to go out of town, and on one occasion, she worked four hours in one day. She tried working five hours a day at one point but had to cut back after one week because she "couldn't do that many hours." (R. 41-42) She stated she calls in sick if she is experiencing "quite a bit of pain," or if her arms "get numb and the numbness won't go away." (R. 42) She also leaves early on occasion because of pain or numbness in her hands, or because she will "get too stressed out if it's too busy of a day." (R. 43) Dunkerson stated her counselor helped her contact the cab company, and she thought her employer allowed her special accommodations as a result of how she got the job. (*Id.*)

Dunkerson explained her low back will give her problems on days when the cab company is very busy and she does not have time to get out of the cab and move around. She explained that when she is driving, she switches positions, leaning from one side to the other, and changing the arms she uses to drive. (*Id.*; R. 78) In a two-hour shift, she normally is able to go home and move around or lie down. She keeps a cell phone with her so she will get calls, and then she will go back out for the call. She stated she usually is not scheduled to work on Mondays, which are the cab company's busiest days. (R. 44)

She stated she sometimes has trouble finding the right addresses. She carries a map with her so she can look up addresses, and she usually writes down her calls when they come in so she can remember the address. (*Id.*) According to Dunkerson, most of the cab customers pay using tickets they obtain through the city, but she occasionally will get a cash call. She makes a written notation when people pay her as to whether they pay with a ticket or in cash, and she stated she sometimes forgets to collect the cash and has to go

back to the customer to collect the payment. According to Dunkerson, this frustrates her boss. (R. 45)

Turning to a discussion of her medical problems, Dunkerson stated her carpal tunnel syndrome began in about 1996, when she started having problems with her hands going numb. It was Dunkerson's understanding that tests showed she had carpal tunnel syndrome "in the wrist, the elbow, and the shoulder," which is why she was having numbness from her fingertips to her shoulders. (R. 49) She stated the pain wakes her up almost every night, and she frequently is in tears because of the pain. (R. 49, 50) She described the sensation as "kind of like needles poking you. Like if your leg goes to sleep or something, you know, or your foot goes to sleep and you have that tingling, you know, needles, that's what my arms do." (R. 49-50) She stated sometimes she has trouble moving her hands and wrists because of the pain. She has difficulty lifting things, such as pans of food when she is trying to cook. She stated her hands sometimes will go numb if she tries to hold her grandson, who weighs twenty to twenty-five pounds. She stated her grandson often crawls up to her and she will lift him into her lap, and she estimated she lifts him off the floor once or twice a week. (R. 50-51)

Dunkerson explained she has not had surgery for her carpal tunnel syndrome because, according to Dunkerson, her doctors have told her the surgery frequently is not successful when the condition goes into the wrist, elbow, and shoulder. However, she noted she has not seen a surgeon for an opinion due to lack of funds. (R. 51) She stated she does exercises to help her wrists stay limber, and she uses heat and takes Ultram and Extra Strength Tylenol. The medications help, but they do not make the pain go away completely. She also sees a chiropractor, who adjusts her wrists. (*Id.*)

Regarding her back problem, Dunkerson stated she hurt her back in 1991, when she was lifting a floor buffer. (R. 51) She reported having constant pain across her low back,

radiating down into her right hip and into her leg to about the knee level. She described the pain as "an aching, throbbing-type." (R. 52) She stated her back always hurts her to some degree, and it hurts more in cold weather or if she walks very far or stands for very long. She has a treadmill, which she uses every other day, "for five minutes or so at a time." (*Id.*) She sets the treadmill at the lowest speed. (R. 75) She had a Stairmaster at one time, but she was unable to use it. (R. 75) Dunkerson stated a physical therapist has her doing leg lifts and crunches at home, and she uses ice on her back almost every day. As with her carpal tunnel syndrome, she stated medication helps her back pain somewhat but does not completely alleviate the pain. (R. 52-53)

Addressing her neck problem, Dunkerson stated she injured her neck in late 1991 or early 1992, when she was in an automobile accident and suffered a whiplash injury. She stated her neck "goes out of place" frequently and causes her to have migraine headaches. (R. 53) She described the pain as "a stabbing-type pain," and noted, "My neck gets real sore to where I can't hardly move it." (*Id.*) She stated the pain radiates down into her shoulders and shoulder blades. The pain is aggravated by lifting; bending her neck from side to side; turning her head, with more pain when turning to the right than the left; and bending her head down, such as when she used a computer at American Home Shield. She stated if she has to bend her neck very much or lift it up, she will get dizzy. (*Id.*) Her neck also bothers her when she is driving. Instead of turning her head to look for traffic, she will turn her whole body around. She stated she has not been referred to an orthopedist because of her lack of medical insurance. To get relief from the pain, she will pop her neck, and alternate applications of heat and ice to the area. (R. 54)

Dunkerson acknowledged that during physical therapy following the car accident, she completed pain scales where she rated her pain anywhere between a 1 and a 4 on a scale of 10. She stated those ratings were in relationship to her normal pain level before

the accident. After the physical therapy, the pain decreased back to her pre-accident level, which is the level she had been describing in her testimony. (R. 55) Dunkerson stated that during physical therapy, she lifted free weights that were strapped to her wrists, rather than being held in her hands. (R. 77, 82) The most she ever was able to lift was seven to ten pounds for fifteen to twenty repetitions. She indicated the exercises were extremely difficult, but she pushed herself as far as she could. She opined she would not be able to maintain that level of lifting throughout the day. (R. 55-56) She also used a MedX machine where she would push a weight back with her whole back and her legs, and she got up to thirty pounds on the machine. (R. 56)

Regarding her mental problems, Dunkerson stated she became depressed after her mother died in February 2000. She described her condition as follows: "I want to sleep all the time. I have no ambitious – no energy. Even when I'm awake, I just kind of sit around and do nothing, don't want to clean the house, don't want to take care of my pets, nothing. All I want to do is curl up and die." (*Id.*) She indicated she has been receiving treatment for her depression, and the medications have helped but she is sill depressed and still feels like she wants to commit suicide. She stated she thinks about suicide "at least two or three times a week." (R. 57) She has thought of driving her car off a bridge, running into something, or getting a gun and shooting herself. She stated that about once a week, there will be a day when she does not get out of bed. On those days, her son takes care of her pets. (*Id.*)

Dunkerson stated she has trouble getting places on time because she does not want to get up and go. She stated, "I would rather stay home because I just don't want to be around people." (*Id.*) Her therapist has told her not to nap during the day, so she will lie down and try to relax, or sit in a recliner with her eyes closed. She stated she sits in the

recliner due to both her depression and her physical problems, and she will sit in the recliner three or four times a day for about a half hour at a time. (R. 58)

Dunkerson complained of difficulty making decisions, such as figuring out which bills to pay, or deciding whether she wants to go somewhere with a friend. She stated she does not like to leave the house. She has a friend who helps her figure out which bills to pay and helps her with paying her bills. (*Id.*) Dunkerson stated she has trouble remembering things that happened in the past, as well as day-to-day things, and she is forgetful and has difficulty concentrating. (R. 78) She has trouble understanding forms she receives in the mail, and she often asks people to repeat things they say because she does not understand them the first time. (R. 78-79)

Dunkerson stated that two or three times a week, she becomes so depressed that she starts crying. She also complained of anxiety and panic attacks, during which she will "get real nervous and start shaking," and feel like she has a lump in her throat, "like your heart's going to stop or going to explode." (R. 59) Her attorney noted Dunkerson had been wringing her hands throughout her testimony, and Dunkerson explained that was due to her nervousness and anxiety. (*Id.*)

Dunkerson stated her depression has affected the way she interacts with people. She explained she gets mad and starts crying, and she will yell at her son, which she did not do previously. (*Id.*) She has problems coping with stress and pressure, and explained she gets very tense about even little things. (R. 79) She has difficulty getting along with some of the people she drives in her cab, but she has been able to control her temper and not blow up at any of her customers. (R. 79-80) She noted she did blow up once when she worked at American Home Shield, and she was reprimanded. (R. 80)

Dunkerson stated she does not have money to pay for any medical services. She continues to see Dr. Motoc and Steve J. Kraus, D.C., a chiropractor who offices with

Dr. Motoc, because they allow her to see them as needed and pay as she is able. (R. 38, 75) She receives some public assistance for medical treatment, and she receives food stamps. (R. 38) She stated she does not see Dr. Motoc as often as she should because of the cost. He gives her samples of her pain pills a couple of times a month, and every two to three months, when she is "really bad," she will go see him. She sees Dr. Kraus at least once a month. (R. 75)

Dunkerson also stated she continues to see her counselor Christine Carlson every other week, and she sees Dr. Liautaud for medication checks every six to eight weeks. She stated she takes Effexor XR, Desaryl as a sleep aid, and Tylenol PM at night. She tried Topomax "for bi-polar," but it made her too tired, and she had trouble staying awake and concentrating on the medication. (R. 76) She stated the only side effect she experiences from her current medications is dry mouth. (*Id.*)

Regarding her physical capabilities, Dunkerson stated she could lift twenty to twenty-five pounds once or twice a day, ten to fifteen pounds more frequently, and five pounds repeatedly. She opined that repeated lifting would cause problems with her wrists. (R. 60) She believes she could stand for fifteen to twenty minutes at a time, and possibly up to half an hour. She stated she "can usually walk a couple of blocks," but then she has to sit down and rest because she is out of breath, feels "real tired," and her hip starts hurting. (R. 61, 77) She believes she could sit for twenty to thirty minutes at a time as long as she could change position, moving and leaning from side to side. Then she would need to stand up for five to ten minutes before she could sit down for another half hour. She stated she has trouble stooping and kneeling, noting that when she gets down, she cannot get back up without assistance from "a table or something to hold onto," or someone to help her up. (*Id.*)

Dunkerson stated she is unable to write for very long at a time, and she has to stop frequently to rest and allow her hands "to go un-numb." (R. 62) She has tried playing games like Solitaire on a computer, but found that after just a few seconds of using the mouse, her hands will begin to tingle and go numb. (*Id.*) She has more problems with numbness in her right hand than in her left, and she is right-handed. (R. 77) She has difficulty opening jars and lifting anything that weighs "very much at all," and sometimes she has problems moving her fingers when she is having pain. (R. 77) She has difficulty climbing stairs because her leg, hip, and low back bother her, but she can climb a few stairs occasionally. (R. 76) When she reaches her arms over her head, it bothers her neck and shoulders. (R. 77-78)

Dunkerson stated she usually gets up about 9:00 or 10:00 in the morning, and goes to bed between 11:00 and 12:00 at night. She stated there are nights when she is unable to sleep and she will not get to bed until around 5:00 a.m. Her depression and anxiety sometime keep her from sleeping, as does her physical pain. (R. 62) Pain in her arms will wake her up. (R. 63)

When she gets up in the morning, Dunkerson will "go into the living room and turn on the TV and either sit down or lay down on the couch." (*Id.*) She plays with her dog for a few minutes, petting the dog and giving her a bone. If Dunkerson is hungry, she will eat something, but she stated that on some days, she does not eat until dinnertime. If she is not working, Dunkerson stays home most of the time. A few times a week, she goes over to a girlfriend's house and spends anywhere from a half hour to three hours with her friend's children, holding them, singing them songs, and telling them stories. She stated she is not at the home alone with the children; her friend or her friend's husband will be there at the same time. (R. 63-64, 65) In the evening, she watches TV. (R. 64)

Dunkerson stated she does her own dishes, when she feels like it. She will put off doing the dishes because her arms start going numb after awhile if she does too much, and the standing bothers her. In addition, she does not feel like doing much due to her depression. (R. 64) She can vacuum for short periods, and usually does one small room at a time. Then she will rest and do another room, and then wait until the next day to continue vacuuming. She stated the laundry basket is in the same room as the washer and dryer so she does not have to carry laundry to the washer. After she washes a load, she will fold the clothes, and then her son will put his clothes away and Dunkerson will put her clothes away. (R. 64-65) She goes grocery shopping a couple of times a week. She stated she does not like to do all her shopping at one time because the bags are heavy and she cannot carry them. The store puts the bags into the car for her, and if her son is not home, then she is unable to get the heavy bags into the house. (R. 65)

Dunkerson stated she had to cut her hair short because it hurt her arms to try to brush the back of her hair. She stated she used to crochet but is unable to do that now. According to Dunkerson, her counselor has recommended she get out of the house more, so she occasionally goes to the "Clubhouse," which is a meeting place for clients of the counseling center. They can get together, read, watch TV, and eat lunch together. Dunkerson would rather visit her girlfriend than go to the Clubhouse because she does not like to be around other people, particularly people who are depressed like she is. She stated "they kind of bring me down more usually." (R. 66)

Dunkerson noted she missed a physical therapy appointment once because she was caring for a child. She stated she cares for the child about once a month, and the child is usually in bed before his mother leaves. On the day she missed her physical therapy appointment, the child was sick, and Dunkerson took the child and his mother to the doctor. (R. 66)

2. Dunkerson's medical history

The court has prepared a detail summary of relevant portions of Dunkerson's medical history, which is attached as Appendix A to this opinion. For that reason, the court will only summarize the medical evidence briefly here.

Dunkerson alleges she is disabled "due to mental problems, bilateral carpal tunnel syndrome, back and hip problems, and migraine headaches." (R. 14) The record indicates Dunkerson was diagnosed with chronic low back pain, neck pain, and muscle spasms in June 1999. (R. 232-33) In addition, her doctor suspected carpal tunnel syndrome (*id.*), and bilateral carpal tunnel syndrome was confirmed by a nerve conduction study in May 2000. (R. 224) She has continued to report bilateral hand numbness, tingling, and weakness since that time. In November 2000, she complained of trouble sleeping, and being awakened by bilateral carpal tunnel pain. (R. 277) She was still complaining of carpal tunnel pain and numbness in her hands on December 27, 2000 (R. 275); March 14, 2001 (R. 269); and November 18, 2001 (R. 328).

For her carpal tunnel syndrome, doctors have recommended electrical stimulation treatment, myofascial release treatment, phonophoresis, physical therapy, cortisone injections, and daily anti-inflammatory medications. (*See* R. 216, 221, 269, 274-77, 390-91) The record indicates Dunkerson received some physical therapy for the condition, and she has been taking Ultram and over-the-counter pain medications for her carpal tunnel syndrome and back pain since at least June 2000. (*See* R. 216-20, 269, 257-58, 299-300, 314-15, 326, 343-44) There is no indication she ever received cortisone injections. She has not consulted with a surgeon regarding the condition, but she testified this was due to lack of funds and medical insurance, and because her doctor said surgery is not always helpful in her type of case.

Dunkerson's long-time treating physician, V. Ted Motoc, M.D., opined in November 2000 that Dunkerson had no limitations in handling objects, as long as she could take regular breaks. (R. 210) Dr. Motoc performed a functional evaluation of Dunkerson in his office on February 12, 2002. (R. 390-91; *see* R. 394) At that time, the doctor found Dunkerson's abilities were unlimited in the areas of reaching, handling (gross manipulation), and feeling (skin receptors). (R. 390-91)

For her chronic low back pain and hip pain, Dunkerson has been treated with physical therapy, chiropractic adjustments, and medications, including Celebrex and Darvocet. In November 2000, Dr. Motoc opined Dunkerson should avoid kneeling, climbing, stooping, or crawling, to prevent aggravating her back pain. (R. 210) James Hardinger, D.O., performed a disability physical of Dunkerson in February 2001, and opined she had "probable degenerative disc disease of the lumbar spine and cervical spine." (R. 234-37) However, there are no X-rays or other test results in the record to support such a diagnosis. Testing did indicate Dunkerson has levoscoliosis, which one medical consultant opined would be affected by Dunkerson's obesity. (R. 252-53) In March 2001, a physical therapy evaluation revealed Dunkerson was not doing any stretches or exercises at home to alleviate her back pain. (R. 241-43)

On June 2, 2001, Dunkerson's back pain was exacerbated when she was in a motor vehicle accident. (*See* R. 315) She took Ultram and Skelaxin, and she received regular physical therapy treatments, chiropractic treatments, and medical follow-up exams for several weeks. (*See* R. 307-14, 350-52, 360-68, 382, 385) On August 8, 2001, she reported her low back was "doing okay" (R. 353), and she was discharged from physical therapy on August 22, 2001, to continue doing exercises on her own. (R. 346-49, 370-79) At the time of her discharge, the physical therapist noted Dunkerson "[c]ontinues to get pain with driving and other specific activities, but is not limited much by the pain."

(R. 347) She reported her pain was 90% to 95% better since she started physical therapy, with improvement in all of her symptoms. (R. 370)

Regarding her migraines, there is little evidence in the record to indicate Dunkerson complained of migraines on a regular basis, and only one reference to treatment for migraines. The record indicates Dunkerson has had migraines since at least August 16, 1999, when a treatment note indicates Dr. Motoc refilled a prescription for Fiorinal. (R. 228) On August 19, 1999, Dr. Motoc noted Dunkerson's migraines were stable. (R. 227)

In July 2000, office notes indicate psychiatrist T.R. Liautaud, D.O. and counselor Christine Carlson both listed migraines among Dunkerson's current diagnoses, with no notes regarding treatment. (*See* R. 294-300) On February 28, 2001, Dr. Motoc saw Dunkerson for complaints of persistent headaches, but he diagnosed these as symptomatic of uncontrolled hypertension. (R. 322) On April 10, 2001, J.D. Wilson, M.D. performed a residual functional capacity assessment of Dunkerson. In his review summary, Dr. Wilson noted Dunkerson did not complain of migraine headaches to him, and he found nothing in her medical records to support her complaints of disabling migraines. (R. 252-53)

Dunkerson's depression is the most severe of her impairments. She became depressed after her mother died in February 2000. She apparently was started on Zoloft at some point, without much success by May 2000. (*See* R. 225) On May 18, 2000, Dr. Motoc noted Dunkerson was complaining of sleeplessness, generalized myalgia, weakness, fatigue, and absence of the desire to get up and perform daily activities. He recommended she take some time off work, increased her Zoloft dosage, and started her on Sonata for insomnia. (R. 225-26) Dunkerson returned for follow-up on May 25, 2000, and reported the increased Zoloft was not effective. She also complained of occipital

headaches, muscle tightness, and persistent pain in the cervical region of her back. Dr. Motoc directed her to stay off work for three weeks. He stopped the Zoloft and prescribed Effexor. (R. 223)

On June 6, 2000, Dunkerson reported she was having no side effects from the Effexor. She felt tired, but denied any suicidal ideation. (R. 222) On June 20, 2000, she reported improvement on an increased dosage of Effexor. (R. 217) She was scheduled for weekly counseling sessions, and had an intake examination on July 7, 2000. (R. 205-09) At that time, she reported having thoughts of suicide at times, and she stated if she killed herself, she would have to take her son with her. She was diagnosed with major depression, recurrent, severe, without psychotic features, and with occasional suicidal ideation. She was referred to Dr. Liautaud for treatment. (*Id.*) Dr. Liautaud apparently recommended Dunkerson remain off work and continue taking Effexor. (*See* R. 216) He also referred her for individual therapy, and added Remeron to her medication regimen. (*See* R. 299-300, 215)

On July 25, 2000, Dunkerson began seeing Christine Carlson, a licensed social worker, for regular counseling sessions, under Dr. Liautaud's supervision. Dunkerson saw Ms. Carlson regularly for individual therapy, and sometimes participated in a women's therapy group, from July 25, 2000, through the time of the ALJ hearing. She also received regular medication checks with Dr. Liautaud. (*See* R. 256-78, 281-93, 324-45) These sessions are summarized in detail in Appendix A. The record indicates that during therapy, Dunkerson worked through a number of issues surrounding her childhood, her mother's death, and her relationship with her son. She had ongoing financial difficulties that added to her emotional problems. On August 1, 2000, when she was still off work, Dunkerson reported she thought her job at American Home Shield was "not right for her anymore," and she told the therapist she had always wanted to own her own

business or run a motel. She agreed to begin exploring what she wanted to do as far as work. (R. 293)

On August 17, 2000, Dunkerson reported that she was staying active, practicing relaxation exercises, and not having panic attacks. She stated she wanted to get back to work. (R. 290) On August 29, 2000, she complained of being tired all the time, but stated she was "still keeping busy with planting, baking, and crocheting to keep her mind 'off things.'" (R. 289) By October 2000, Dunkerson's condition had not improved markedly, and on October 12, 2000, Dr. Motoc directed her to stay off work for another four weeks. (R. 211) At a regular medication check with Dr. Liautaud on November 21, 2000, Dunkerson was "given suggestions for employment such as hotel desk clerk and [advised] to talk to Job Service as it was felt that it would be a period of time before she received disability." (R. 276)

On January 23, 2001, Dunkerson indicated she would like to drive a taxi cab. She interviewed for the job in the therapist's office and was hired. (R. 273) At her next session on January 30, 2001, she reported that she had started the job and was really enjoying driving the cab, although it was giving her some problems with her back. (R. 271; *see* R. 270) Dunkerson was showing some improvement in mood by March 2001. She had not had a return of her suicidal thoughts and was sleeping well. (R. 269) On March 29, 2001, Dunkerson told her therapist she was "contemplating another job," and she was considering her options, but she felt physically that she would not be able to work very many hours. (R. 267) On April 13, 2001, she indicated she wanted to increase her hours driving the cab. She reported feeling good when she was working and stated she usually enjoyed her job. (R. 266)

At a regular medication check with Dr. Liautaud on June 13, 2001, Dunkerson reported feeling depressed, but not suicidal. She stated she had experienced "some mood

swings, irritability, temper and frustration," but she felt "quite well" during the exam. (R. 257-58) On June 25, 2001, Dunkerson told her therapist she was working five hours per day, and she was depressed, feeling anxious, and sleeping a lot. (R. 256) At her next session on July 31, 2001, she indicated her hours had been cut to about five per week, "due to possible closing of [the] company." (R. 345) She had gained weight, and reported that although her mood was improved somewhat, she still had rapid mood swings. (*Id.*) She missed her next therapy appointment (*see* R. 341-42), and at her medication check on August 21, 2001, she told Dr. Liautaud she sometimes did not want to go to work "because she is agoraphobic and doesn't want to be around people." (R. 339) She reported "only slight improvement in mood swings, irritability, temper and anger control and frustration." (*Id.*)

Dunkerson cancelled her next therapy appointment on August 27, 2001, and did not see her therapist again until September 18, 2001, when she reported "no depression." (R. 336) She reported she had made changes to her medications on her own and was feeling more alert. She stated she was babysitting and driving the cab. (*Id.*) At her next session on October 2, 2001, Dunkerson reported sleeping late into the morning and during the day, and then hardly sleeping at night. The therapist addressed Dunkersons's "cognitive distortions about her inability to work (can't thinking, all or nothing thinking, over-generalization, and catastrophizing)." (R. 335) Dunkerson agreed to think about the possibility of working as a desk clerk at a hotel/motel, and babysitting. (*Id.*) The therapist told Dr. Liautaud that Dunkerson had low motivation to find a job, and she had been turned down for SSI a second time and was looking for an attorney. (R. 333) She reported Dunkerson was depressed, but the depression was not as bad as it had been, and she was not suicidal. (*Id.*)

Dunkerson missed her therapy sessions on October 15 and 22, 2001 (R. 330-32). When she next saw her therapist on October 26, 2001, she reported "feeling overwhelmed and at times suicidal" due to the denial of her application for disability benefits. (R. 329) She stated she "was finally able to look at some job possibilities but she was not able to build the necessary energy to do any more than that. She continue[d] to feel that she must take care of and provide a home for her adult son who [was] not working." (*Id.*) The therapist noted Dunkerson was "deep into her negative thought patterns." (*Id.*) Notes from Dunkerson's November 20, 2001, therapy session indicate she believed she was unable to work, and this belief system was "pretty well entrenched." (R. 327) The therapist planned to "continue to chip away at her belief system." (*Id.*)

At a medication check on December 6, 2001, Dr. Liautaud noted Dunkerson was doing somewhat better and reported feeling "fairly stable." She enjoyed working with her therapist and was sleeping better. She stated she was still driving a cab intermittently, and she was doing some babysitting, but she was still having financial difficulties. He assessed her GAF at 63, which would indicate mild symptoms or some difficulty with social and occupational functioning. (R. 326; *see* DSM-IV, at 32 (4th ed. 1994)) At Dunkerson's therapy session on December 11, 2001, she was "slightly less depressed," but otherwise showed "very little progress." (R. 325)

At her next session on January 4, 2002, Dunkerson reported working five to nine hours a week. She "stated that she and her son would like to buy a bar in Dedham and run it themselves," and she appeared to be "excited about something for the first time in a long time." (R. 324) She planned to talk to the bar's former owner about how to run the business. (*Id.*) By the time of the ALJ hearing in February 2002, Dunkerson apparently was still taking Effexor, Remeron, Trazodone, and Ultram. (*See* R. 326)

Dunkerson underwent several consultative evaluations that are part of the record. Dee E. Wright, Ph.D., performed a Mental Residual Functional Capacity Assessment on February 26, 2000. He found Dunkerson to be moderately limited in her ability to carry out detailed instructions; maintain attention and concentration for extended periods; complete a normal workday and workweek without interruptions from psychologically based symptoms; perform at a consistent pace without an unreasonable number and length of rest periods; get along with coworkers or peers without distracting them or exhibiting behavioral extremes; and respond appropriately to changes in the work setting. Otherwise, he found her to have no significant limitations. (R. 194-96)

Dr. Wright also conducted a Psychiatric Review Technique, from which he concluded Dunkerson suffers from disturbance of mood accompanied by a depressive syndrome, and evidenced by decreased energy, difficulty concentrating or thinking, suicidal thoughts, and anxiety. He found that due to her condition, Dunkerson is mildly limited with regard to her activities of daily living and maintaining social functioning. He further found she had experienced one or two episodes of decompensation, each of extended duration. (R. 197-202) In a supplement to the Psychiatric Review Technique, Dr. Wright opined Dunkerson "would have difficulty consistently performing extremely complex cognitive activity that would require prolonged attention to minute details and rapid shifts in alternating attention. Despite this restriction, [she] currently appears able to sustain sufficient concentration and attention to perform a range of non-complex repetitive and routine cognitive activity when she is motivated to do so." (R. 203) He opined she has no severe restrictions of function from a psychological perspective with regard to the activities of daily living or social functioning. (*Id.*)

James A. Hardinger, D.O. performed a disability physical of Dunkerson on February 27, 2001 (R. 234-37). Dunkerson told Dr. Hardinger she felt she could lift or

carry "about 20 pounds infrequently during the day," and stand, move about, walk, and sit about fifteen to twenty minutes each during an eight-hour day. She reported difficulties stooping, climbing, kneeling, and crawling, and noted she "has low back pain if she travels for more than 45 to 60 minutes in a car." She reported having trouble holding onto objects due to numbness in her hands secondary to carpal tunnel syndrome. She stated she has problems with dust due to allergies. (R. 234)

Dr. Hardinger's examination indicated Dunkerson had average ranges of motion in her shoulders, good ranges of motion in her elbows, and good ranges of motion in her wrists. Her hands could be fully extended, fingers could be opposed, and she could make a fist. He assessed her grip strength as slightly below normal (4 on a scale of 1-5, where 5 is normal) in both hands. (R. 236) He found she could squat, walk on her toes, and walk on her heels. She exhibited ranges of motion slightly below average in her lumbar and cervical spinal regions. He indicated she had slight muscle weakness on both sides, but he failed to indicate the extremity or muscle in which he found the weakness. (R. 237) He opined Dunkerson had "probable degenerative disc disease of the lumbar spine and cervical spine." (R. 235) However, this diagnosis was not confirmed by X-rays, which indicated "Levoscoliotic curvature of mild severity," and no "acute osseous abnormality." (R. 238)

Dunkerson underwent an occupational therapy evaluation on March 15, 2001. (R.239-40) The evaluator noted Dunkerson "demonstrated poor confidence in her ability to complete tasks[,] requiring encouragement to attempt tasks during the evaluation. Her maximum lifting abilities place her in the light work category. . . . [She] demonstrate[d] significant amounts of deconditioning and [could] benefit from a work hardening program should she return to gainful employment." (R. 240) A concurrent physical therapy evaluation revealed the following: "[Dunkerson's] range of motion and strength in her

lower extremities did appear to be within very functional limits. [She] does appear to be de-conditioned. She is having some lumbar discomfort, which is most likely due to her scoliosis. [She] is not doing any type of stretching or exercise for her low back at this time. [Her] gait is also limited due to her conditioning." (R. 241) Dunkerson exhibited ranges of motion similar to those she exhibited during Dr. Hardinger's examination. (*Compare* R. 242-43 *with* R. 236-37)

J.D. Wilson, M.D. performed a Physical Residual Functional Capacity Assessment of Dunkerson on April 10, 2001. (R. 244-51) He found she can lift/carry twenty pounds occasionally and ten pounds frequently; stand, walk, and sit, with normal breaks, for a total of six hours in an eight-hour workday; and push and pull without limitation. She occasionally can climb ramps, stairs, ladders, ropes, and scaffolds; and balance, stoop, kneel, crouch, and crawl. She has no limitation in her ability to reach in all directions, handle, and feel, and only slight limitation in the ability to finger (fine manipulation). She has no visual, communicative, or environmental limitations. (*Id.*) Dr. Wilson found Dunkerson to have the following medically-determinable impairments consisting of "Levoscoliosis, lumbar spine, bilateral ulnar and median neuropathy with CTS, Level 1 obesity." (R. 252) He noted Dunkerson performs the activities of daily living consistently with a level that her pain complaints would dictate; however, he found her pain complaints were not supported by the medical evidence of record. He found Dr. Motoc's opinion that Dunkerson has marked restrictions of exertional and postural activities was not supported by the evidence. He similarly found Dr. Hardinger's opinion was not fully supported by the evidence, noting Dr. Hardinger had simply reiterated Dunkerson's "self-assessment of her capacity." (R. 253) On August 17, 2001, Claude H. Koons, M.D. reviewed the medical evidence and concurred with Dr. Wilson's evaluation. (R. 323)

On February 12, 2002, Dr. Motoc performed a functional capacity evaluation and examination of Dunkerson. (R. 390-91) He found she can safely lift and carry twenty pounds occasionally; safely lift thirty-three pounds occasionally from the floor level, twenty-nine pounds from the leg level, and forty-two pounds from the arm level. She can lift and carry ten pounds frequently; sixteen pounds frequently from the floor level, fourteen pounds from the leg level, and twenty-one pounds from the arm level. He found that all of these tests passed recognized validity criteria.

Dr. Motoc further found Dunkerson can stand and walk, with normal breaks, for six hours in an eight-hour workday, as long as she can pause five to ten minutes on an hourly basis. She can sit, with normal breaks, for six hours in an eight-hour workday, but sitting should be limited to forty-five minutes at a time with a five- to ten-minute break afterwards. She is unlimited in her capacity to push/pull within the above restrictions, and she reported no fatigue or pain during a pushing/ pulling simulation consisting of sixty repetitions each.

Dr. Motoc does not recommend that Dunkerson climb, stoop, kneel, crouch, or crawl up to one-third of the time, due to her low back pain and hip pain; however, she could do these activities "at least once/hour." She has no limitations on reaching, handling (gross manipulation), or feeling (skin receptors).

He listed Dunkerson's current diagnoses as chronic low back pain, generalized anxiety disorder, depression, and carpal tunnel syndrome. The doctor opined Dunkerson could work in a job that accommodates her limitations, and she could work eight hours a day as long as she can rest five to ten minutes every hour. She needs to take anti-inflammatory pain medications daily to control her chronic low back and hip pain. The doctor opined Dunkerson could perform better in February 2002 than she could in November 2000. (*Id.*)

In response to questioning from the ALJ, Dr. Motoc clarified his functional capacity evaluation as follows:

> The reason why I recommended a five to ten minutes break every fifty minutes is to allow more rest to her lumbar musculoskeletal system. These breaks can consist of alternative activities that would also provide the required rest to her back area. For example she may very well continue to work in a standing position for at least five to ten minutes after . . . prolonged sitting activities and vice versa.

(R. 394)

John F. Wallace, Ph.D. examined Dunkerson on February 12, 2002, for the purpose of assessing her current intellectual capabilities. (R. 392-93) He administered the Wechsler Adult Intelligence Scale - Third Edition (WAIS-III), which indicated Dunkerson has a Verbal IQ of 85, Performance IQ of 89, and Full Scale IQ of 86. Dunkerson had a long response time for both correct and incorrect answers. She exhibited no general intellectual deficits, but she did have a low Verbal Comprehension Index and low Processing Speed Index when compared with other indexes. Dr. Wallace opined the test results likely reflected a valid assessment of Dunkerson's current intellectual functioning. He concluded Dunkerson "experiences particular problems associated with the comprehension of verbal material and the ability to process visual material rapidly," which could "constitute a predisposition to developing deficits associated with reading, because reading requires the rapid and sequential processing of visual information." (R. 393) With respect to her work-related abilities, Dr. Wallace opined Dunkerson's "deficit in processing speed would be expected to have an adverse impact [on her] ability to maintain appropriate work pace." (*Id.*)

3. Vocational expert's testimony

The ALJ instructed the VE not to include the cab driver job as substantial gainful activity. The ALJ stated the VE should include the reservations clerk job even though it was part-time. The ALJ noted Dunkerson was paid "almost over $9000 for the year that she worked at that position," and the ALJ found the job constituted substantial gainful activity. (R. 83) After some clarification from Dunkerson, the VE completed a summary of Dunkerson's past work activity, which was entered into evidence in the Record. (*See* R. 185)

The ALJ then asked the VE the following hypothetical question:

> My first assumption is that we have an individual who is 46 years old. She was 44 years old as to the alleged onset date of disability. She is a female with a high school education and past relevant work as you've indicated in [the work summary], and she has the following impairments. She has cervical [INAUDIBLE], with a history of cervical strain, medically determinable impairment resulting in complaints of low back, hip and leg pain. History of Carpal Tunnel Syndrome, hypertension, history of migraine headaches, obesity, history of fibromyalgia, a major depressive disorder, generalized anxiety disorder, panic disorder without agoraphobia and a history of dyslexia. As a result of a combination of those impairments, she has the residual functional capacity as follows. This individual should not lift more than 20 pounds, routinely lift 10 pounds. No standing of more than 45 to 60 minutes at a time, no sitting of more than 45 to 60 minutes at a time, and no walking of more than 45 to 60 minutes at a time, with no repetitive bending, stooping, squatting, kneeling, crawling or climbing. No repetitive pushing or pulling of more than 20 pounds. Her grip, gross, and fine manipulation are intact, but she should avoid frequent repetitive upper extremity movements. She should not repetitively work with her arms overhead. She should not be exposed to more than moderate levels of vibration. She is not able to do very complex or technical work, but is able to do more than simple,

> routine, repetitive work, which does not require constant attention to detail or constant contact with the public. She does require occasional supervision. She should not work at more than a regular pace and [I'm] choosing three speeds of pace, being fast, regular and slow. She should not work at more than a mild to moderate level of stress. Would this individual be able to perform any jobs she previously worked at[,] either as she performed it or as it is generally performed within the national economy?

(R. 86-87)

The VE stated the hypothetical individual would not be able to return to any of her past work activity, stating as follows: "The standing, sitting, and walking limitations, in my opinion, would preclude her past jobs with the exception of the authorizer or warranty clerk dispatcher, because she used a headphone in that job, which would allow for some standing, sit[t]ing flexibility. But it did require certainly constant contact with the public and/or employees." (R. 88)

In addition, the VE opined there would be no skills the hypothetical claimant had acquired from her past work that could transfer to other work within the limitations in the hypothetical. (*Id.*) The VE noted the hypothetical claimant's skills, "as far as clerical machine operation, in my opinion would be precluded because that does require sitting, usually for longer than 45 to 60 minutes at a time. Her oral communication skills, which would allow for sitting/standing flexibility within the limits of [the] parameter, would require constant contact with the public." (*Id.*)

The VE concluded the hypothetical individual would be unable to perform either the full range or even a wide range of unskilled work activity. (*Id.*) However, there still would be some unskilled jobs the individual could perform within the hypothetical's limitations, including surveillance system monitor and office helper. (R. 89) The VE stated the office helper job would "allow for some sitting/standing flexibility." (*Id.*) The

VE noted there are approximately 300 surveillance system monitor jobs in Iowa, and approximately 32,000 in the United States, and there are approximately 1500 office helper jobs in Iowa and approximately 140,000 such jobs in the United States. (*Id.*) The VE clarified that the numbers of office helper jobs given reflect all office helper jobs, not just those that would allow the individual to alternate between sitting and standing. (R. 91) Although the VE could not provide numbers for office helper jobs that would allow alternate sitting and standing, the VE opined that almost half of those jobs would allow sitting/standing flexibility within the time parameters specified in the hypothetical. (R. 91-92)

The ALJ posed a second hypothetical question to the VE, as follows:

> My next hypothetical would be an individual of the same age, sex, education, past relevant work and impairments as previously specified. And this would be an individual who would have the residual functional capacity as follows. This individual could not lift more than 20 to 25 pounds, routinely lift five to 10 pounds, with no standing of more than 20 to 30 minutes at a time, no sitting of more that [sic] -- excuse me, no standing of more than 15 to 30 minutes at a time, no sitting of more than 20 to 30 minutes at a time, and no walking of more than two blocks at a time. No repetitive – or no more than occasional bending, stooping, twisting of the neck, squatting, kneeling, or climbing. No repetitive pushing or pulling. No repetitive work with the arms overhead. No repetitive string gripping or gross or fine manipulation or repetitive handling. And by handling, I mean using the wrists to twist or turn objects[.] She is able to do only simple, routine, repetitive work, which does not rely on written material, and does not require constant close attention to detail or use of independent judgment or decision making. She does require occasional supervision. She cannot work at more that [sic] a regular pace and should not work at more than a mild level of stress. I assume this individual could not return to past relevant work,

> transfer acquired work skills, or perform the full and/or wide range of unskilled work activity. Would that be correct?

(R. 88-89) The VE agreed the individual could not return to her past work and would not have transferable skills acquired in past work.

The VE opined there would not be other unskilled jobs the individual could perform within the hypothetical's limitations, stating, "I think the sitting/standing limitations, in and of themselves, would so limit the pace of any job that it would take her out of competitive employment. And in addition to that, the stress level of mild would certainly preclude the two jobs that I identified earlier." (R. 90-91)

4. The ALJ's conclusions

The ALJ found that although Dunkerson had worked as a cab driver since March 2001, her earnings were insufficient for that work to qualify as substantial gainful activity. (R. 14) He found Dunkerson had not engaged in any substantial gainful activity since her alleged disability onset date of May 17, 2000. (R. 14; R. 25, ¶ 2)

The ALJ found Dunkerson "has the following medically determinable impairments, the combination of which is severe under the [Social Security] Act and Regulations: cervicalgia with a history of cervical strain; history of carpal tunnel syndrome; hypertension; history of migraine headaches; obesity; history of fibromyalgia; major depressive disorder; generalized anxiety disorder; panic disorder without agoraphobia; and a history of dyslexia." (R. 26, ¶ 3; R. 20) He held none of these impairments, singly or in combination, meet the regulatory requirements for a finding of disability. (*Id.*; *see* R. 14-20)

In the ALJ's written opinion, he set forth the sequential evaluation process specified by the Regulations for evaluating Dunkerson's physical limitations, mental limitations, and

credibility. For numerous reasons, discussed further below, the ALJ concluded Dunkerson's subjective complaints of pain and limitations were not supported by the evidence. He noted several inconsistencies between Dunkerson's testimony and the record evidence. The evidence indicates that in August 2000, Dunkerson told her therapist most of her mental symptoms were arising at "the thought of going back to American Home Shield," her prior employer. The ALJ found this statement suggested "not that [Dunkerson] had been unable to perform other work, but has been unreasonably unwilling to do so." (R. 15) He noted she had taken some items to a fair and had won some first and second place ribbons, and she reported to her therapist that she was keeping herself busy with planting, baking and crocheting. (*Id.*)

The record further indicates that in November 2000, Dunkerson's treating psychiatrist noted some suggestions were given to Dunkerson regarding types of work she might do, such as hotel desk clerk, and she was advised to talk with "'Job Service as it was felt that it would be a period of time before she received disability.'" (R. 16) The ALJ found the doctor's comment "evidence[d] an opinion of some capability to work." (R. 16)

The ALJ noted Dunkerson continued to report improvement in her symptoms over time. She enjoyed driving a cab and planned to increase the number of hours she was working. She also reported doing some babysitting. She regularly denied suicidal ideation, driving difficulties, and side effects from her medications, and in December 2001, she reported that she was stable. (R. 17) The ALJ found, "The babysitting and continued cab driving also show involvement in a range of daily activity not consistent with impairments of a work precluding degree of severity." (*Id.*)

The ALJ also observed that Dunkerson had expressed the desire to buy a bar in a small town and run it with her son. He noted, "While the performance of such a job may

exceed her functional capacity, [Dunkerson's] feeling that she had a measure of functional capacity sufficient to perform work is consistent with other substantial evidence." (R. 17)

The ALJ discounted Dunkerson's testimony that her work pace was inappropriately slow, and he similarly discounted the opinion of psychologist Dr. Wallace, who opined Dunkerson's "deficit in processing speed would be expected to have an adverse impact on her ability to maintain an appropriate work pace." (*Id.*) The ALJ noted Dr. Wallace only examined Dunkerson on one occasion, he was not a treating source, and his opinion was not consistent with other evidence in the record. The ALJ pointed to Dunkerson's continued activity driving the cab, noting "the ability to drive requires the ability to react to changing traffic situations, traffic signs and traffic signals, at times instantaneously. There is no indication in the record that [Dunkerson] has had repeated accidents from her failure to process visual information rapidly and react immediately/at times instantaneously and appropriately." (*Id.*) The ALJ further noted Dunkerson had never been terminated from a job due to inadequate pace, and she had worked successfully at a variety of jobs. (*Id.*)

The ALJ discounted the opinion of James A. Hardinger, D.O., who performed a consultative physical examination of Dunkerson, because, in the ALJ's view, the doctor's opinion was based in large part on Dunkerson's unsupported, subjective allegations concerning the existence, persistence, and intensity of her symptoms. (R. 19) The ALJ found the medical evidence did not "support the existence of a back related impairment or joint related impairment that could reasonably be expected to produce [Dunkerson's alleged] symptoms." (R. 20) The ALJ therefore found Dunkerson's alleged symptoms concerning her back and joints would not affect her ability to do basic work abilities. (*Id.*)

Turning to Dunkerson's mental limitations, the ALJ found the evidence indicates Dunkerson has a history of major depressive disorder, a generalized anxiety disorder, and

a panic disorder. The ALJ explained his duty to evaluate Dunkerson's mental impairment as follows:

> Once the presence of medically determinable impairments is substantiated, the Administrative Law Judge must rate the degree of functional limitation resulting from the impairments in four broad functional areas: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. . . . A five-point scale is used in the first three areas: none, mild, moderate, marked, and extreme. When rating the fourth functional area (episodes of decompensation), a four-point scale is used: none, one or two, three, and four or more. A mental impairment that results in a limitation rating of "none" or "slight" in the first three functional areas, and "none" in the fourth area, will generally be an impairment that is "not severe."

(R. 18, citing 20 C.F.R. §§404.1520a(c) & 416.920a(c))

Applying this evaluation process to the evidence at hand, the ALJ found as follows regarding Dunkerson's "functional limitations resulting from her mental impairments":

> [I]n the area of activities of daily living, [Dunkerson] has a mild degree of limitation; in the area of social functioning, [she] has a mild to moderate degree of limitation. Crocheting, submitting award winning projects to a fair, babysitting, and driving a cab all suggest involvement in a wide range of activity and little problem with exposure to others, even strangers. In the area of concentration, persistence, or pace, [she] has a mild degree of limitation shown by her ability to drive, among others. The ability to drive infers [sic] a higher degree of concentration necessary to be aware of and respond appropriately and at times instantaneously to changing traffic signs, signals and situations. In the area of episodes of decompensation, [she] has a rating of none. The evidence does not establish the presence of a residual disease process resulting in such marginal adjustment that even a minimal increase in mental demands or change in the environment would cause

> decompensation, nor is there a demonstrated inability to function outside a highly supportive living arrangement.

(R. 18)

The ALJ gave "significant weight" to the opinions of the State agency's consulting psychologists, Dr. Wright and Dr. Notch, but noted that in light of other evidence not available to those consultants, he had arrived at a different residual functional capacity than was determined by the consultants. (*Id.*)

The ALJ further evaluated Dunkerson's subjective complaints under the *Polaski* factors (discussed later in this opinion), and he found Dunkerson's testimony not to be credible under those factors. In examining the evidence regarding Dunkerson's daily activities, the ALJ noted that numerous inconsistencies between Dunkerson's testimony and what she reported from time to time to her treating medical professionals indicated she had "not been fully accurate in describing the nature, location, existence, duration, frequency and intensity of her symptoms and alleged limitations to others, including [the ALJ]." (R. 22)

Similarly, in the area of the duration, frequency, and intensity of Dunkerson's pain, he found her testimony was inconsistent with her statements to medical professionals, and also with the medical evidence. He noted recent medical records showed "no persistent complaints," and her daily activities were "not consistent with substantial hand limitation." (*Id.*) Although the ALJ acknowledged that the record indicates Dunkerson has an upper extremity limitation, he found "it was not preclusive of the performance of a significant number of jobs." (*Id.*)

No inconsistency was noted between Dunkerson's testimony and the record evidence concerning side effects from her medications. She repeatedly reported no adverse side effects, and the ALJ found, "No side effect of any medication is found to have been

established which would credibly reduce [Dunkerson's] residual functional capacity beyond that found for her by the [ALJ]." (*Id.*)

Regarding Dunkerson's functional limitations, the ALJ reviewed in detail both Dunkerson's own opinion regarding her abilities, and the opinions of her treating physicians and the consultants. The ALJ gave little weight to Dr. Motoc's November 2000 opinion, finding the record evidence did not support that opinion regarding Dunkerson's functional limitations. (R. 23) The ALJ gave greater weight to Dr. Motoc's opinion in February 2002, as clarified by his response to the ALJ's follow-up questions in March 2002. At that time, Dr. Motoc opined Dunkerson could lift and/or carry "20 pounds occasionally up to 1/3 of the time and 10 pounds frequently"; lift and/or carry "at least 10 pounds frequently up to 2/3 of the time . . . [and] lift up to 16 pounds from floor level"; "stand or walk 6 hours in an 8-hour workday," and "work 6-8 hours per day as long as she was allowed to pause 5 to 10 minutes per hour"; "sit for 6 hours with the ability to pause 5 to 10 minutes after"; "push or pull up to 20 pounds"; and "she should avoid frequent repetitious fine motor movements." (*Id.*) Dr. Motoc clarified that the five- to ten-minute breaks each hour would be for the purpose of resting Dunkerson's lumbar spine, and she could continue to perform alternate activities during those periods, "such as standing after prolonged sitting or vice versa." (R. 24) The ALJ found Dr. Motoc's February 2002 opinion to be "more consistent with the record as a whole," and the ALJ included in the RFC posed to the VE "the ability to change positions after 45 (to 60) minutes and . . . avoid frequent repetitive upper extremity movements." (*Id.*) The ALJ found the "remaining capabilities did not preclude vocational adjustment to a number of jobs[.]" (*Id.*)

The ALJ afforded "no weight" to Dr. Motoc's opinion that Dunkerson should avoid occasional climbing, stooping, kneeling, crouching, and crawling due to low back pain,

because "no medically determinable impairment has been established as a basis for low back pain." (*Id.*) The ALJ noted, however, that due to Dunkerson's "obesity and other impairments," she "should avoid performing such activities on a repetitive basis." (*Id.*)

Considering all of the *Polaski* factors and the Record as a whole, the ALJ concluded Dunkerson's "allegation of a complete inability to work is not consistent with the evidence of record," and her "impairments are not as limiting as she alleges." (*Id.*) He found Dunkerson has the following residual functional capacity:

> [She can] lift a maximum of 20 pounds, 10 pounds routinely; standing up to 45 to 60 minutes at a time; sit for 45 to 60 minutes at a time; walk 45 to 60 minutes at a time. [She] must avoid repetitive bending, stooping, squatting, kneeling, crawling, or climbing; and repetitive pushing or pulling more than 20 pounds. [Her] grip, gross manipulation and fine manipulation abilities are intact but [she] must avoid frequent, repetitive upper extremity movements. There should be no repetitive work with the arms overhead; no exposure to more than a moderate level of vibration. [She] is not able to do very complex, technical work, but is able to do more than simple, routine, repetitive work. The work should not require constant attention to detail or constant public contact. There should be occasional supervision. [She] is able to work at a regular pace and must avoid more than a mild to moderate level of stress.

(*Id.*)

Having determined Dunkerson's RFC, the ALJ determined Dunkerson is unable perform any of her past relevant work, consisting of "an authorizer, service representative/dispatcher; sales clerk; cashier; crew person; cook; reservation clerk; housekeeper; and cab driver." (R. 24-25) The ALJ found, however, that Dunkerson is capable of performing substantial gainful activity in other work that exists in significant numbers in the regional and national economies. Two such jobs include surveillance system monitor,

which is a sedentary, unskilled job, and officer helper, which is a light, unskilled job. (R. 25)

Based on his findings, the ALJ held Dunkerson was not disabled at any time through August 20, 2002, and he denied her applications for benefits. (R. 25, 27)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step sequential evaluation process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *Dixon v. Barnhart*, ___ F.3d ___, 2003 WL 22990119 at *2 (8th Cir. Dec. 22, 2003); *Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner will consider a claimant's work activity. If the claimant is engaged in substantial gainful activity, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(i).

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see "whether the claimant has a severe impairment that significantly limits the claimant's physical or mental ability to perform basic work activities." *Dixon*, 2003 WL 22990119, at *2. The United States Supreme Court has explained:

> The ability to do basic work activities is defined as "the abilities and aptitudes necessary to do most jobs." . . . Such abilities and aptitudes include "[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling"; "[c]apacities for seeing, hearing, and speaking"; "[u]nderstanding, carrying out and remembering simple instructions"; "[u]se of judgment"; "[r]esponding appropriately to supervision, co-workers, and usual work situations"; and "[d]ealing with changes in a routine work setting."

Bowen v. Yuckert, 482 U.S. 137, 140-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987) (citing 20 C.F.R. §§ 404.1521(b), 416.921(b)); *accord Lewis v. Barnhart*, ___ F.3d ___, 2003 WL 23025545, at *2 (8th Cir. Dec. 30, 2003) (citing *Bowen*, *inter alia*).

Third, if the claimant has a severe impairment, then the Commissioner will consider the medical severity of the impairment. If the impairment meets or equals one of the presumptively disabling impairments listed in the regulations, then the claimant is considered disabled, regardless of age, education, or work experience. 20 C.F.R. § 404.1520; *Kelley*, 133 F.3d at 588.

Fourth, if the claimant's impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant's residual functional capacity ("RFC") to determine the claimant's "ability to meet the physical, mental, sensory, and other requirements" of the claimant's past relevant work. 20 C.F.R. §§ 404.1520(4)(iv); 404.1545(4); *see Dixon*, *supra*. The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the

claimant's RFC, but the Commissioner is responsible for developing the claimant's "complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant's] own medical sources." 20 C.F.R. § 404.1545(3). The Commissioner also will consider certain non-medical evidence and other evidence listed in the regulations. *See id.* If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(iv).

Fifth, if the claimant's RFC as determined in step four will not allow the claimant to perform past relevant work, then the burden shifts to the Commissioner "to prove that there is other work that [the claimant] can do, given [the claimant's] RFC [as determined at step four], age, education, and work experience." Clarification of Rules Involving Residual Functional Capacity Assessments, etc., 68 Fed. Reg. 51,153, 51,155 (Aug. 26, 2003). The Commissioner must prove not only that the claimant's RFC will allow the claimant to make an adjustment to other work, but also that the other work exists in significant numbers in the national economy. *Id.*; 20 C.F.R. § 404.1520(4)(v); *Dixon, supra*; *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)); *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000). If the claimant can make an adjustment to other work that exists in significant numbers in the national economy, then the Commissioner will find the claimant is not disabled. If the claimant cannot make an adjustment to other work, then the Commissioner will find the claimant is disabled. 20 C.F.R. § 404.1520(r)(v).

B. The Substantial Evidence Standard

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra,* 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra,* 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler, id.*; *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier,* 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell*, 242 F.3d at 796*; Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that evidence appropriate weight when determining whether the overall evidence in support is substantial." *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (also citing *Cline*, *supra*).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does not "reweigh the evidence presented to the ALJ," *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or "review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *accord Baldwin*, 349 F.3d at 555. This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier,* 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse the Commissioner's decision "merely because substantial evidence would have supported an opposite decision." *Baldwin*, 349 F.3d at 555 (citing *Grebenick v. Chater*, 121 F.3d 1193, 1198 (8th Cir. 1997); *see Pearsall,* 274 F.3d at 1217; *Gowell*; 242 F.3d at 796; *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823

F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS

Dunkerson argues the ALJ erred in failing to evaluate properly the credibility of her subjective complaints, failing to include limitations documented by the medical evidence in his RFC assessment, and presenting an inaccurate hypothetical question to the VE. (*See* Doc. No. 13) The court will address each of Dunkerson's arguments.

A. Credibility Determination

Dunkerson argues that although the ALJ went "to great lengths to recite the *Polaski* standard and SSR 96-7p," he failed to evaluate her credibility appropriately under those standards. (*Id.*, p. 6) If Dunkerson's subjective complaints are credited fully, then she would be unable to work and would be disabled. (*See* VE's testimony, R. 90-91)

Dunkerson recites several instances where she claims the ALJ failed to consider evidence that detracted from his decision. (*See id.*, pp. 6-12) For example, she argues there is no evidence she obtained lasting benefits from the physical therapy she received after her automobile accident, and she notes that she "testified she was functioning at about the same level as before the accident[.]" (*Id.*, p. 6) She argues the ALJ's finding that her daily activities are inconsistent with her subjective complaints was made "only by ignoring significant portions of her testimony." (*Id.*, p. 7) She argues nothing in the record refutes her claim that she must rest three to four times daily for half an hour at a time. (*Id.*, p. 11)

The problem with these arguments is they rely on the very evidence the ALJ found was not fully credible; *i.e.*, Dunkerson's own testimony. More importantly, the issue is not whether Dunkerson experiences pain and limitations as a result of her impairments -- the evidence clearly establishes that she does. The "crucial question" is whether Dunkerson's "credible subjective complaints prevent [her] from performing any type of work." *Gregg v. Barnhart*, ___ F.3d ___, 2003 WL 23025605, at *2 (8th Cir. Dec. 30, 2003) (citing *McGinnis v. Chater*, 74 F.3d 873, 874 (8th Cir. 1996)). The ALJ did not completely discount Dunkerson's subjective complaints; rather, he found her "allegation of a *complete inability to work* is not consistent with the evidence of record," and "[t]he record as a whole supports a finding that [her] impairments are *not as limiting as she alleges*." (R. 24; emphasis added)

Dunkerson further argues the ALJ failed to consider evidence that she has difficulty sleeping. (Doc. No. 13, p. 6) She notes that "[i]n June 2001, when she tried to work five hours a day, she 'slept all the time.'" (*Id.*, citing R. 256) The evidence does not support Dunkerson's interpretation of the record. Therapist Christine Carlson's progress note dated June 25, 2001, states, in pertinent part, as follows:

> **PROGRESS TOWARD GOALS:** [Dunkerson] is anxious. She is sleeping "all the time". We practiced relaxation exercises. She is working five hours per day now which is an improvement. She is in the process of moving again. She is anxious around this. We discussed how she needed to do those things that will help her to fight the depression. She agreed to stop napping during the day, to cook healthy meals, and to listen to upbeat music.

(R. 256) The record does not indicate working five hours a day was the cause of Dunkerson's "sleeping all the time." In fact, Dunkerson reported "she feels good when working," which is why she increased her hours. (*See* R. 266)

Dunkerson notes the ALJ criticized her "activities such as baking, driving, and crocheting as inconsistent with her allegations of pain in her hands." (Doc. No. 13, p. 7, citing R. 22) She seizes on the fact that the record indicates she complained, in November 2000, that crocheting caused her hands and arms to go numb, and "she testified she had no hobbies and no longer crocheted." (*Id.*) The ALJ did not base his evaluation of Dunkerson's daily activities solely on her statement to her therapist, on August 29, 2000, that she was keeping herself busy with planting, baking, and crocheting. (*See* R. 289) The ALJ also pointed to a number of other activities that he found to be inconsistent with Dunkerson's allegations that her impairments prevented her from doing any type of work. For example, in addition to planting, baking, and crocheting, he noted Dunkerson was doing some babysitting, she continued to drive a cab, and she had taken some craft items

to a fair and won some first and second place ribbons. (R. 15-17) He also noted Dunkerson expressed an interest in buying a bar and running it with her son. While the ALJ recognized this type of activity might exceed Dunkerson's RFC, he found her belief that she would be able to perform that type of work to be inconsistent with her allegation that she is completely disabled. (R. 17)

Dunkerson claims the record contains evidence to contradict the ALJ's finding that she had not had "'repeated accidents from her failure to process visual information rapidly and react immediately/at times instantaneously and appropriately.'" (Doc. No. 13, p. 8, quoting R. 17) The evidence to which she points is an automobile accident in June 2001, and two moving violations. The record indicates the accident likely would have been virtually unavoidable regardless of her ability to react. She described the accident as follows: "I was driving north on Clark about 25 mph. The truck in front of me turned into a driveway and then backed right back out and hit [the] passenger side front finder [sic] and door." (R. 318) The tickets she received were for speeding and for going around a stopped school bus (*see* R. 264), neither of which implicates Dunkerson's ability to process information and react appropriately.

Dunkerson further argues her "attempts to work part-time should not be held against her." (Doc. No. 13, p. 8) She argues the ALJ applied a "presumption" that she was not disabled "merely because [she] had a lenient employer, a high tolerance for pain, or no other means of support." (*Id.*) Again, the court disagrees with Dunkerson's interpretation. In reaching his decision that Dunkerson's impairments are not as limiting as she alleges, the ALJ repeatedly pointed to the *abilities* required for Dunkerson to drive a cab, rather than to the fact that she was employed part-time.

Dunkerson claims the ALJ failed to acknowledge her medications, "other than to assert her condition was controlled with medication." (Doc. No. 13, p. 10) This

statement is in error. The ALJ noted Dunkerson repeatedly reported she was experiencing no adverse side effects from her medications. Indeed, she testified at the ALJ hearing that the only side effect she experienced was dry eyes. Dunkerson further claims nothing in the record contradicts her testimony that her medications do not control her depression. (*Id.*, p. 11) However, the record indicates Dunkerson has remained at the same levels of Effexor since July 2000, and her Remeron was increased only once, in November 2000, and has remained at the same dosage since that time.[1] If the medications provided no relief, it is reasonable to think Dunkerson would have complained of this fact to her doctors and requested a change in the medications. *See Roth v. Shalala*, 45 F.3d 279, 282 (8th Cir. 1995) (impairment is not disabling if it can be controlled by treatment or medication).

"If the ALJ explicitly discredits the claimant's testimony and gives good reason for doing so, [the court] will normally defer to the ALJ's credibility determination." *Gregg*, 2003 WL 23025605 at *2 (citing *Russell v. Sullivan*, 950 F.2d 542, 545 (8th Cir. 1991)). The ALJ may discount a claimant's subjective complaints when the ALJ "explicitly finds them inconsistent with daily activities, lack of treatment, demeanor, and objective medical evidence." *Long v. Bowen*, 866 F.2d 1066, 1067 (8th Cir. 1989) (citing *Polaski*). In the present case, the court finds the ALJ undertook a proper credibility analysis, and his articulation of the inconsistencies upon which he relied and his reasons for discounting

[1] *See* R. 299, 07/18/00 (Effexor XR 150 mg. in the morning, 75 mg. at h.s.; start Remeron 7.5 at h.s.); R. 279-80, 10/17/00 (continue same levels); R. 276-77, 11/21/00 (continue Effexor XR 150 mg. in the morning, 75 mg. at h.s.; increase Remeron to 15 mg. at h.s.); R. 274-75, 12/27/00 (continue same levels; notes indicate Dunkerson did not request increase in medications); R. 269, 03/14/01 (continue same levels); R. 267-58, 06/13/01 (continue same levels); R. 343-44, 06/02/01 (continue same levels); R. 339-40, 08/21/01 (continue same levels); R. 333-34, 10/04/01 (continue same levels); R. 326, 12/06/01 (continue same levels).

certain evidence were appropriate and complete. The court finds the ALJ's credibility findings are supported by substantial evidence on the record as a whole.

B. Residual Functional Capacity Assessment

Dunkerson argues the ALJ failed to include in his RFC assessment all of the limitations in her physical and mental functional abilities that are documented by the medical evidence. Regarding her physical RFC, Dunkerson argues there are "significant differences" and "subtle distinctions" between the limitations found by Dr. Motoc in his functional capacity evaluation and those found by the ALJ in his RFC. Specifically, Dunkerson notes Dr. Motoc specified she should only sit for forty-five minutes at a time, with a five- to ten-minute pause afterwards to rest her back. The ALJ found Dunkerson could sit for forty-five to sixty minutes at a time. She claims the ALJ's RFC failed "to specifically include the need to alternate positions[.]" (Doc. No. 13, pp. 13-14)

"The RFC 'is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to do work-related activities.' S.S.R. 96-8p, 1996 WL 374184, at *3 (Soc. Sec. Admin. July 2, 1996)." *Depover v. Barnhart*, 349 F.3d 563, 565 (8th Cir. 2003). In making his RFC determination, the ALJ was required to consider statements about what Dunkerson is able to do from her treating medical sources, from other medical sources even if they were not based on formal medical examinations, and from Dunkerson herself. *See* 20 C.F.R. § 404.1545(a)(3). As was the case in *Depover*, "Here the 'relevant evidence' included [Dunkerson's] own description of [her] pain and limitations, *see Anderson v. Shalala*, 51 F.3d 777, 779 (8th Cir. 1995), which the ALJ considered and found not to be fully credible." *Id.* *See Baldwin*, 349 F.3d at 556.

In addition, the ALJ noted he not only was considering Dr. Motoc's opinion, but he also gave "a good deal of weight" to the opinions of the State agency consultants who

had "reviewed the record and made note of the most pertinent findings and inconsistencies." (R. 23) In April 2001, J.D. Wilson, M.D. found that Dunkerson can sit, with normal breaks, for a total of six hours in an eight-hour workday. (R. 245) Claude H. Koons, M.D. reviewed the record and concurred in this finding on August 17, 2001. (R. 323) Taking into consideration a ten-minute break every hour, as Dunkerson urges, the ALJ's assessment that she can sit for "45 to 60 minutes at a time" is an accurate assessment of her RFC, and allows for the ability to change positions after forty-five to sixty minutes of sitting.

Dunkerson argues that equally "egregious is the complete absence of substantial evidence to support the ALJ's mental residual functional capacity [assessment]." (Doc. No. 13, p. 14) Specifically, she argues the ALJ erred in discounting Dr. Wallace's opinion that her "'deficit in processing speed would be expected to have an adverse impact [on her] ability to maintain an appropriate work pace.'" (*Id.*, quoting R. 393) She argues Dr. Wallace's opinions are supported by her hearing testimony, her therapists's estimate of her intellectual functioning, and Dr. Wright's opinion. (*See id.*, p. 15)

The ALJ cited several reasons for discounting Dr. Wallace's opinion regarding the "deficit" in Dunkerson's processing speed, and for finding less than credible Dunkerson's testimony that she worked at an inadequate pace. Dr. Wallace examined Dunkerson on one occasion, he was not a treating source, and the ALJ found his opinion was not consistent with other evidence in the record. The ALJ noted Dunkerson had never been terminated from a job due to inadequate pace, and she had worked successfully at a variety of jobs. He also pointed to the abilities required for Dunkerson to drive a cab successfully. (*See* R. 17) The court finds the ALJ properly and appropriately supported his decision to discount Dr. Wallace's opinion and Dunkerson's testimony regarding her work pace limitations.

Regarding Dr. Wright's opinion, the ALJ noted he had given significant weight to the opinions of Drs. Wright and Notch, but in light of other evidence in the record that was not available to those consultants, the ALJ arrived at a different RFC than the consultants had determined. (R. 18) In particular, Dr. Wright did not have available the records from Dunkerson's ongoing counseling, which indicate Dunkerson continued to improve and reported more than once that she was not experiencing depression. Furthermore, even without the additional records regarding Dunkerson's continued improvement during therapy, Dr. Wright noted that despite Dunkerson's limitations, she still would be able "to sustain sufficient concentration and attention to perform a range of non-complex repetitive and routine cognitive activity when she is motivated to do so." (R. 203) The court finds the ALJ properly rejected the opinions of both Dr. Wallace and Dr. Wright because they are inconsistent with the record as a whole. *See Bentley v. Shalala*, 52 F.3d 784, 787 (8th Cir. 1995).

Dunkerson claims the record does not contain a statement from any examining source, other than Dr. Wallace, as to her mental limitations, and she argues, without citing any supporting authority, "This alone is cause for remand." (Doc. No. 13, p. 16) Although no other examining source provided an opinion specifically for purposes of Dunkerson's disability applications, Dr. Liautaud and Ms. Carlson kept extensive treatment notes regarding Dunkerson's progress. The ALJ found the doctor's comments indicated Dunkerson had "some capability to work" (R. 16), and the ALJ noted Dunkerson reported improvement in her symptoms over time, and repeatedly denied suicidal ideation or driving difficulties. He further noted Dunkerson reported she was fairly stable in December 2001. (R. 17) These progress notes from Dunkerson's treating physician and counselor constitute appropriate evidence upon which the ALJ could rely in formulating his RFC assessment. *See* 20 C.F.R. § 404.1545(3).

This is not a case where the ALJ relied solely on the opinions of non-treating medical consultants, with a record so devoid of evidence that the ALJ had a duty to develop the record further. Nor is this a case where the medical evidence of record is so "cryptic and without sufficient detail or opinion for a trier of fact to be able to reach a fair conclusion." *Lande*ss v. *Weinberger*, 490 F.2d 1187, 1189 (8th Cir. 1974); *see Nevland v. Apfel*, 204 F.3d 853, 858 (8th Cir. 2000) (Reliance on "the opinions of non-treating, non-examining physicians who reviewed the reports of the treating physicians to form an opinion of [the claimant's] RFC . . . does not satisfy the ALJ's duty to fully and fairly develop the record.")

Rather, in the present case, the ALJ had a wealth of medical evidence upon which to rely regarding Dunkerson's mental condition. The court finds the ALJ reasonably resolved the conflicts in the evidence, and his decision regarding Dunkerson's RFC, both physical and mental, is supported by substantial evidence in the record as a whole.

C. Hypothetical Question

Dunkerson argues the ALJ's hypothetical question to the VE did not accurately reflect her abilities. The Eighth Circuit has held an ALJ's hypothetical question must fully describe the claimant's abilities and impairments as evidenced in the record *See Chamberlain v. Shalala*, 47 F.3d 1489, 1495 (8th Cir. 1995) (citing *Shelltrack v. Sullivan*, 938 F.2d 894, 898 (8th Cir. 1991)). A hypothetical question is "sufficient if it sets forth the impairments which are accepted as true by the ALJ." *Johnson v. Chater*, 108 F.3d 178, 180 (8th Cir. 1997); *House v. Shalala*, 34 F.3d 691, 694 (8th Cir. 1994). Only the impairments substantially supported by the record as a whole must be included in the ALJ's hypothetical. *Cruze v. Chater*, 85 F.3d 1320, 1323 (8th Cir. 1996) (citing *Stout v.*

Shalala, 988 F.2d 853, 855 (8th Cir. 1993)). *See Wiekamp v. Apfel*, 116 F. Supp. 2d. 1056, 1073-74 (N.D. Iowa 2000) (Bennett, C.J.).

The court has found the ALJ properly determined Dunkerson's RFC based on the totality of the evidence, and, with one exception, his hypothetical to the VE included those limitations he found to be credible and supported by the record as a whole. The exception relates to the extent of Dunkerson's education. Dunkerson points out the hypothetical stated only that she had a high school education, failing to mention that she was in special education classes for reading and math. The court agrees Dunkerson's education should have been portrayed accurately in the hypothetical. However, the court finds the error was harmless.

The ALJ may produce evidence of suitable jobs by eliciting testimony from a VE "concerning availability of jobs which a person with the claimant's particular residual functional capacity can perform." *Cox v. Apfel*, 160 F.3d 1203, 1207 (8th Cir. 1998). As the Commissioner notes in her brief (*see* Doc. No. 14, pp. 13-14), Dunkerson worked for many years in jobs that require *higher* levels of reasoning and communication skills than the two jobs the VE cited as examples of work Dunkerson would be able to perform. Therefore, the ALJ's error in failing to include Dunkerson's special education history in the hypothetical question was harmless. *Cf. Morris v. Bowen*, 864 F.2d 333, 336 (5th Cir. 1988) (Appeals Council found claimant could not operate machinery; VE's list of jobs included jobs requiring use of machinery; court held no error when list of jobs also included jobs not requiring use of machinery). The court finds the ALJ's hypothetical to the VE reasonably incorporated Dunkerson's disabilities and limitations.

V. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[2] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be affirmed, and judgment be entered for the Commissioner and against Dunkerson.[3]

IT IS SO ORDERED.

DATED this 20th day of January, 2004.

PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[2]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

[3]NOTE: If the district court overrules this recommendation and final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.

APPENDIX A

MEDICAL RECORDS SUMMARY
Dunkerson vs. Barnhart, Case No. C03-3002-MWB

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
06/16/99 R. 232-33	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Pain in neck, head, low back, knee, feet, extremities	Pt has the following complaints: Neck pain and tightness; persistent headaches; low back pain with tingling and numbness in both lower extremities; knee pain, right greater than left; foot pain, left more than right; numbness and tingling in both upper extremities. Assessment: 1. Neck pain. Recommend modalities and change medication to Celebrex; discontinue Ibuprofen. 2. Muscular spasms. Myofascial release techniques and Flexeril. 3. Upper extremities numbness and tingling. Ordered nerve conduction study to rule out carpal tunnel syndrome (CTS) versus cervical pathology. Pt to wear a brace and continue modalities. 4. Chronic low pain. Consider physical therapy. 5. Chronic knee pain. X-rays taken. Will refer to physical therapy if needed. 6. Plantar fasciitis, bilateral, left more than right. Pt to wear heel cushions and use Cortisone cream. If not better in four weeks, will give Cortisone injection. 7. Lower extremities numbness and tingling. Suspect lumbar pathology.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
07/08/99 R. 231	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re heel and neck pain, numbness in upper extremities	Pt still experiencing numbness and tingling in upper extremities, better since treatment started. Assessment: 1. Chronic neck pain. Continue current treatment for one more week. 2. Upper extremities numbness and tingling. Improved. Continue same treatment. 3. Heel pain secondary to plantar fasciitis. Continue current treatment.
08/09/99 R. 230	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Acute bronchitis, cough; follow-up re pain	Cervicalgia - continue current treatment. Plantar fasciitis - continue current treatment; if not better, order cortisone shot.
08/11/99 R. 229	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Acute bronchitis, cough; follow-up re pain, weakness	Cervicalgia - continue current treatment. Plantar fasciitis - continue current treatment. Joint pain - rule out gout; check uric acid, basic metabolic profile, CBC, TSH. Generalized Weakness - rule out sleep apnea; history of loud snoring.
08/16/99 R. 228	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Left foot, upper respiratory infection	Continue current treatments. Refill Fiorinal for migraines. Check X-ray re joint pain and continue Ibuprofen as needed.
08/19/99 R. 227	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Left foot swelling and pain	X-ray showed "impressive heel spur." Start ultrasound and cortisone treatments. Migraines stable.
05/17/00 R. 14, 109, 399	**Dunkerson's Claimed Disability Onset Date**	**Mental problems, bilateral carpal tunnel syndrome, back and hip problems, migraine headaches**	

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
05/18/00 R. 225-26	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Back pain, bilateral upper extremity numbness	Pt reevaluated for back pain and bilateral upper extremity numbness. Pt reports a lot of stress in recent months due to her mother's terminal condition and death. Since that time, Pt has been unable to sleep more than a few hours a night. Pt started reporting generalized myalgia, weakness, fatigue, absence of desire to wake up and perform daily activities. Pt reports difficulty at work and problems focusing on her job. Pt tried Zoloft without much success. Pt was extremely anxious and crying throughout interview. Dr. recommended Pt take some time off work, increase her anti-depressant medication, and take some sleeping pills for a short period of time. Pt's neck pain may be related to current emotional turmoil. Assessment: 1. Major Depression 2. Generalized Anxiety Disorder 3. Muscular Spasm 4. Cervicalgia Plan: Pt off work for the next week; increase Zoloft; start Sonata for insomnia.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
05/25/00 R. 223	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Increased Zoloft was not effective. Pt is still having sleeping problems, emotional lability, concentration incapacity, weakness, fatigue, and lack of desire to get things done. Pt reports numbness, persistent cervical pain and muscular tightness. Pt gets headaches that start in her occipital area. Assessment: 1. Major Depression 2. Generalized anxiety disorder. 3. Muscular spasm. 4. Cervicalgia. Plan: Pt off work for next three weeks. Stop Zoloft and start Effexor.
05/25/00 R. 224	Lisa Banchik, M.D.	Upper extremity nerve conduction study	Impression: 1. Bilateral ulnar neuropathy. 2. Bilateral carpal tunnel syndrome with sensory involvement only.
06/06/00 R. 222	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Pt takes Effexor with no side effects. Pt feels tired; denies any suicidal ideation. Assessment: 1. Major depression. Increase Effexor. Samples given. 2. Generalized anxiety disorder. 3. Muscular spasm. 4. Cervicalgia
06/08/00 R. 221	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Numb hands	Pt seen for evaluation and discussion of nerve conduction tests results. She continues to experience bilateral hand numbness, tingling, and weakness. Minimal improvement in her emotional status, and she continues to take Effexor. Physical therapy was instructed to address carpal tunnel syndrome treatment with Pt. Compared to one year ago, it appears Pt's

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			symptoms became bilateral and increased in nerve conduction abnormality. Assessment: 1. Major Depression. Continue Effexor and refer Pt to psychiatry specialist for more evaluation. 2. Generalized Anxiety Disorder. Pt on Effexor. 3. Carpal tunnel syndrome. 4. Ulnar nerve neuropathy. Plan: Recommend electrical stimulation treatment, myofascial release treatment, and phonophoresis for carpal tunnel syndrome. If no improvement, Pt will have bilateral cortisone injections.
06/16/00 R. 218-20	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re weakness, depression, fatigue, sleepiness	Increase Effexor. Continue staying off work. Follow up with counseling. Continue current treatment and Ultram.
06/20/00 R. 217	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Good results with Ultram and improvement with Effexor. Pt scheduled for weekly counseling visits and feels much better since starting treatment. Assessment: 1. Depression 2. Anxiety disorder 3. Chronic low back pain. 4. Carpal tunnel syndrome. Plan: Continue Effexor, physical therapy program, and Ultram.
07/07/00 R. 205-09	St. Anthony Regional Hospital Jim Dardis, L.I.S.W.	Depression; suicidal thoughts	Pt reports depression and suicidal thoughts since mother's death in February. Pt cared for her mother for ten years. Pt feels guilty; feels she should have done more for her mother. Pt is having difficulty sleeping, concentration problems; has been off work since 05/18/00

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			because of depression, and doesn't feel she could work at this time. Pt is currently taking Effexor and Sonata. Pt still has thoughts of suicide at times, but states if she killed herself, she would have to take her son with her; son has emotional problems. Pt's is having financial difficulties and may have to declare bankruptcy. Pt has run out of med samples and cannot afford co-pay for meds. Pt is being sued for nonpayment of some bills. Pt's work history includes working for American Home Shield for 5 1/2 years, waitressing work, housekeeping in a hospital for 7 1/2 years; she owned her own janitorial business; and she worked in a convenience store. Pt's current complaints are back pain from work-related injury; neck pain from a car accident. Plan: Due to the complexity of Pt's problems and need for medication, she is referred to Carroll Regional Counseling Center to see Dr. Liautaud. He can prescribe medications and access medication assistance program. Diagnostic Impression: Axis I: Major depression, recurrent, severe, without psychotic features, with occasional suicidal ideation. Axis II: Personality disorder - deferred. Axis III: Back and neck problems due to old injuries. Axis IV: Psychosocial environmental problems: problems with finances, inade-

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			quate insurance, son who has multiple psychological problems. Axis V: Current GAF is 55; highest in the last year 65.
07/11/00 R. 216	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Pt was seen by Dr. Liautaud, who recommended she continue off work while taking Effexor. Assessment: Major Depression. Off work. Continue Effexor. Carpal tunnel syndrome; continue physical therapy. Right shoulder tendinitis; Ultram samples given, physical therapy recommended. Insomnia; Sonata samples given.
07/18/00 R. 299-300	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Psychotropic medication check	Pt referred by Dr. Motoc for depression and suicidal ideation. Pt also reported nervousness, anxiety, panic disorder symptoms, history of sleeping excessively or not at all. Pt reports depression is improved since Effexor was increased. Suicidal ideation is less, but continues to have sleep problems and takes Sonata as needed. Pt no longer takes Darvocet, but instead takes Ultram. Current medications: Effexor, Ultram, Sonata. Current Diagnosis: Axis I: Major Depressive Disorder, recurrent, severe, without mood congruent psychotic features, with history of suicidal ideation, improved; Generalized Anxiety Disorder, improved; Panic Disorder with Agoraphobia, improved; Continue to rule out Bipolar Disorder; Parent/child

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			relational problems related to her mother and son; Alcohol abuse with alcohol dependence by history. Axis II: Deferred. Axis III: Bilateral carpal tunnel, arthritis of right hip, migraines, chronic low back pain secondary to motor vehicle accident; hypertension; bronchial asthma; bronchitis; history of nicotine abuse; gastroenteritis; arthritis. Axis IV: Problems with primary support group; problems related to social environment; rule out employment problems. Axis V: GAF 55. GAF in the last year: 48. Plan: Pt referred to individual therapy and will be referred for Patient Assistance Program for Effexor and Remeron.
07/25/00 R. 294-98	Carroll Regional Counseling Center Christine Carlson, LISW	Intake Assessment	Pt is a 44-year-old divorced female who resides in Audubon with her son. She is referred by Jim Dardis. Pt is depressed and suicidal and states she would take her son with her. Pt is not sleeping, is suicidal, feels hopeless and helpless, is eating less, has no motivation and no energy, feels tired all the time. She started to feel depressed in February, when her mom died, but didn't see anyone until May when Dr. Motoc referred her to Dr. Liautaud. Pt states her mother was alcoholic, mentally abusive, and her boyfriends were abusive. Pt graduated from high school in 1974. She was in special education, skipped

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			school a lot, had few friends, and was teased about the way she dressed. Pt had several jobs: Casey's twice, Payless Shoes twice; McDonald's, and finally six years at American Home Shield. She is unable to work at the present time. Pt's first suicidal thoughts occurred at age 20, when she thought about jumping off a bridge. She has felt this way five times since. Current medications: Effexor, Ultram, Colistat and Celebrex. Pt started drinking at age 14; quit at age 18; started again and drank from age 20-22; 30-35; now drinks occasionally. Pt tried marijuana once, but didn't like it. She has a history with amphetamines. She did take "downers to sleep." Pt sleeps only with the help of Sonata. Provisional Diagnosis: Axis I: Major Depressive Disorder, recurrent, severe, with suicidal ideation; Generalized Anxiety Disorder; rule out Bipolar Disorder and Dysthymic Disorder. Axis II: Deferred. Axis III: Allergies to Erythromycin, Aspirin and Codeine. Heart murmur, migraines, neck and back problems, bad rotator cuff, hypertension, asthma, gastroenteritis, arthritis and carpal tunnel. Axis IV: Problems related to primary support group, social environment, employment and financial. Axis V: Current GAF 50. Recommendations: Attend regular medication checks;

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			women's depression group, and weekly individual therapy.
08/01/00 R. 215	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Pt was started on Remeron by Dr. Liautaud in addition to Effexor.
08/01/00 R. 293	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt is "improved in mood and dress and grooming" and attitude is less depressed. Affect is improved and Pt has no suicidal ideation. Pt expressed difficulty thinking about returning to work at American Home Shield, stating "she had to make herself go" every day. Pt "feels that her job is not right for her anymore" and discussed options with therapist; stated she always wanted to own her own business or run a motel. Pt will get book "What Color Is My Parachute," and explore what she wants to do as far as work.
08/04/00 R. 292	Carroll Regional Counseling Center	Emergency contact	Pt called last night very upset, sobbing uncontrollably, hyperventilating, having difficulty thinking, stuttering. She had an altercation with the Sheriff's Department regarding her dog. Pt was alone, felt scared, and had thoughts of suicide. Pt was talked through some simple relaxation techniques to help her calm down and stop hyperventilating. Pt was able to calm down, breathe more regularly, take her medications, and get in bed.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
08/11/00 R. 291	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt was anxious, but pleasant and cooperative. Pt's dog was shot last weekend. Pt has to go to court for a ticket re her dog. Discussed relaxation exercises. Pt "was able to make some future plans" and had gotten the recommended book.
08/11/00 R. 214	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Pt had a "terrible week"; had "a nervous breakdown"; called crisis hot line and talked for two hours. Assessment: Major Depression, Generalized Anxiety Disorder. Continue Effexor and Remeron.
08/17/00 R. 290	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt "[a]ppears somewhat manic." Pt is staying active; reports no panic attacks; practices relaxation exercises. Pt is working through grief about her dog being shot. Pt's son is working which is positive for her. Pt "would like to get work and decrease the anxiety."
08/19/00 R. 213	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Back pain	Celebrex samples given. Continue Effexor and Remeron. Continue outpatient therapy.
08/29/00 R. 289	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt "was anxious, wringing her hands, and somewhat depressed but cooperative." Discussed family history of mental health problems. Pt's mother tried to commit suicide twice. Her son, several aunts, uncles, and a brother have mental health problems. Pt has had flashbacks and dreams of abuse by her father, half brothers and husband; feels she deserved

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			abuse by her ex-husband. She was also molested by an older man when she was five or six. Pt "reported being tired all the time and angry at herself." Pt advised not to sleep too much. She is "still keeping busy with planting, baking, and crocheting to keep her mind 'off things.'" Pt to attend group for depressed women.
09/08/00 R. 212	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Pt reports having no energy, feeling depressed. Continue psychotherapy outpatient program and exercise program.
09/11/00 R. 288	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt's mood was depressed and she was "opinionated but cooperative." Pt was found guilty of having vicious dogs; fined $90 or 30 days in jail. "She was warned about her bad attitude after cursing at the judge and telling him she would not pay the fine and he could take her to jail today." Pt reports not sleeping well. She has a dry mouth and states the medication is not helping her sleep. Pt reports her father was abusive. Also states her step-brother "was really bad and abusive and at one point she wanted to shoot him with a rifle." Pt to continue attending women's group.
09/18/00 R. 287	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status: "No change."

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
09/26/00 R. 286	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status: "No change." Continued anxiety and depression. Pt worries about her son "most of the time." She may still be going to jail because she refuses to pay the fine re her dogs. Pt checked on disability for herself and her son, and HUD housing, which therapist viewed as "progress." They discussed Job Corps as a possibility.
10/03/00 R. 285	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status: Pt is depressed but not suicidal; upset over financial problems. Recommended emergency assistance as Pt can no longer afford food and gas; Pt to check on it. Pt feels hopeless; states "things just keep getting worse no matter what she does." "She was somewhat agreeable to try a paper route or babysitting to at least be able to afford a little food and gas."
10/05/00 R. 284	Carroll Regional Counseling Center Christine Carlson, LISW Darlene Warnke, LISW Intern	Group Therapy	Pt was "more expressive" than she had been previously. She gave encouragement and suggestions to other group members.
10/10/00 R. 283	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt was tired and anxious, but "slightly less depressed." She reported "'weird dreams,' restlessness, not sleeping well, jumpy, uneasy and irritable." Pt stated things were bothering her that normally wouldn't. Pt reported feeling less depressed and stated she "leaves her curtains open now where she didn't

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			before." Pt reported numbness in her arms at night and pain in arms all day. "She doesn't feel she will be able to go back to work for quite awhile."
10/12/00 R. 282	Carroll Regional Counseling Center Christine Carlson, LISW	Group Therapy	Pt "had difficulty expressing her emotions, [but] with some thought she was able to share her feelings."
10/12/00 R. 211	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re depression	Pt reports having no energy, no desire to get anything done, no desire in social life. Affect is flat. Pt taking meds as directed; denies suicidal intentions. Assessment: 1. Major Depression: continue Effexor and Remeron; continue current multi disciplinary approach; stay off work for next four weeks. 2. Anxiety Disorder: continue Effexor. 3. Chronic low back pain: Rx for Darvocet N 100. Pt instructed not to drive, operate machinery, or drink alcohol while taking her medication. 4. Carpal tunnel syndrome: reassess next visit.
10/16/00 R. 281	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status: "No change." Pt is "depressed but not suicidal." Pt has to go to court on a contempt charge for nonpayment of fine on her dogs; states she doesn't want to pay the fine on principle, and also she doesn't have the money; says she will go to prison if fine is not paid. Therapist suggested Pt plead for mercy due to financial hardship. Pt is feeling restless, anxious, depressed. Pt will

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			continue attending group.
10/17/00 R. 279	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt is on Effexor XR, Remeron, Darvocet N 100, Sonata. Pt denies "side effects, driving difficulties, day time sedation, or suicidal ideation." Pt complains she is not sleeping well, and she has pain in her wrist, shoulder, elbow, and arthritis in her hip. Continued current meds; recommended Tylenol for pain.
10/23/00 R. 278	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt failed to appear for scheduled appointment.
11/16/00 R. 210	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Opinion letter	Pt's diagnoses are Major Depression, Anxiety Disorder, Chronic Low Back Pain, and Carpal Tunnel Syndrome. Pt sees Dr. Ted Liautaud, a psychiatrist. Re RFC, Pt can lift 5-10 occasionally; can stand, sit, walk, and move around without limitation if she gets a 10-min. break every 45-60 mins. Pt should not kneel, climb, stoop, or crawl, to prevent aggravating her back pain. Pt has no limitations re handling objects, with regular breaks. No concerns re seeing, hearing, speaking, environmental considerations or hazards.
11/21/00 R. 276-77	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt is currently on Effexor and Remeron. She was on Darvocet and Sonata, but has no income to afford those medications. Pt had "some slight pressured speech but not significant." Pt

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			complains of trouble sleeping, and being awakened by bilateral carpal tunnel pain. Pt denies side effects from meds; reports Tylenol P.M. helps somewhat. Pt to continue taking Effexor and Remeron, which she receives through patient assistance program. "She was also given suggestions for employment such as hotel desk clerk and to talk to Job Service as it was felt that it would be a period of time before she received disability."
12/27/00 R. 274-75	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt has "some pressured speech"; reported sleeping better; still having carpal tunnel pain but otherwise is stable and does not request any increase in her meds. She denies side effects from meds, excessive sedation, appetite increase, or GI symptoms. Pt somewhat stressed by recent move to HUD housing and inability to bring her dog; however, Pt reports fewer crying spells and mood swings; denies driving difficulties and suicidal ideation. Continue current meds.
01/23/01 R. 273	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status unchanged. Discussed Pt's transportation and money problems. Pt has no phone and her son uses her car all the time so she cannot get out. Pt would like to drive a cab. She interviewed in therapists's office and got the job.
01/30/01	Carroll Regional Counseling	Therapy session	Pt is less depressed; has a phone

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
R. 272	Center Christine Carlson, LISW		now, started driving a cab and really enjoys it, and is getting out more.
02/15/01 R. 271	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt is less depressed; grooming and dress were improved. Pt's "new job driving a cab is going well for her. She loves it except for some problems with her back."
02/26/00 R. 194-96 (NOTE: erroneously dated 02/26/00)	Dee E. Wright, Ph.D. Clinical Psychologist	Mental Residual Functional Capacity Assessment	Pt is moderately limited in her ability to carry out detailed instructions; maintain attention and concentration for extended periods; complete a normal workday and workweek without interruptions from psychologically based symptoms; perform at a consistent pace without an unreasonable number and length of rest periods; get along with coworkers or peers without distracting them or exhibiting behavioral extremes; and respond appropriately to changes in the work setting. Otherwise, no significant limitations.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/26/01 R. 197-202 (NOTE: erroneously dated 02/26/00)	Dee E. Wright, Ph.D. Clinical Psychologist	Psychiatric Review Technique	RFC based on Affective Disorders and Anxiety-Related Disorders. Pt has disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by decreased energy, difficulty concentrating or thinking, and suicidal thoughts. Pt has anxiety as the predominant disturbance or anxiety experienced in the attempt to master symptoms. Pt is mildly limited in activities of daily living and maintaining social functioning. Pt is moderately limited in ability to maintain concentration, persistence or pace. Pt has had one or two repeated episodes of decompensation, each of extended duration.
02/26/01 R. 203-04	Dee E. Wright, Ph.D.	Supplement to Psychiatric Review Technique	Pt has medically determinable mental impairments including "a Major Depressive Disorder, recurrent, a Generalized Anxiety Disorder and a Panic Disorder with agoraphobia." These create moderate restrictions of function including some difficulties with sustained concentration and attention; thus, she "would have difficulty consistently performing extremely complex cognitive activity that would require prolonged attention to minute details and rapid shifts in alternating attention. Despite this restriction, [Pt] currently appears able to sustain sufficient concentration and attention to

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			perform a range of non-complex repetitive and routine cognitive activity when she is motivated to do so." No restrictions in social interaction or activities of daily living.
02/27/01 R. 234-37	McFarland Clinic, P.C. James A. Hardinger, D.O.	Disability physical	Pt is "a 45-year-old white female who is claiming disability due to back pain, shoulder pain and wrist pain." Pt feels she can lift 20 lbs. infrequently during the day; stand, move about, walk, and sit for about 15 to 20 minutes at a time; difficulty stooping, climbing, kneeling, and crawling. Pt reports "trouble holding onto objects because of the numbness in her hands secondary to the carpal tunnel syndrome." Pt reports back pain if she travels in a car for more than 45-60 mins.; and problems with dust due to allergies. Report lists Pt's range of motion in all areas. "Assessment: Carpal tunnel syndrome with secondary numbness to the shoulder and probable degenerative disc disease of the lumbar spine and cervical spine."
02/27/01 R. 238	McFarland Clinic, P.C. T. Gleason, D.O.	Lumbar spine X-rays	"Levoscoliotic curvature of mild severity. Intervertebral disc space heights preserved. No evidence for acute osseous abnormality."

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/28/01 R. 322	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Persistent headaches	Pt has headaches bilaterally in her templates; denies visual or auditory symptoms, chest pain, shortness of breath, abdominal pain. BP 174/100. Assessment: Poorly controlled hypertension; on no medication; Rx for Atenolol. Continue Effexor.
03/01/01 R. 270	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt "feels more anxious and is having headaches and her blood pressure is higher." Pt reports "some suicidal ideation but wouldn't do it due to her son and has no plan." "She is pretty positive about driving cab a couple hours a week but states that this hurts her back and she has to get out often to stretch, etc." Pt to call if she has serious thoughts of suicide.
03/12/01 R. 321	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Blood pressure check	Pt reports no side effects from Atenolol. Increase dosage; continue to check BP daily.
03/14/01 R. 269	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Unscheduled medication check	Pt is seen today for an unscheduled appointment. Pt had "less pressured speech." Pt reports sleeping well; continued problems with carpal tunnel, but otherwise feeling better re mood. Pt works part-time for local taxi company and denies driving difficulties. No return of suicidal ideation. Current meds: Effexor, Remeron, Celebrex, Ultram, Tylenol PM. Pt denies side effects.
03/15/01 R. 239-40	St. Anthony Regional Hospital Kaylene Sodawasser, OTR/L	Occupational Therapy Evaluation	Pt referred by State medical consultant for OT evaluation. Pt reports former employment at

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			American Home Shield from Nov. 1994 thru Feb. 2001. Pt took medical leave, was let go, and no full-time job since then. Pt drives a cab part time; "seems to be tolerating that task well." Pt reports prior EMG of upper extremity revealed "bilateral carpal tunnel as well as right shoulder and elbow difficulties." "[A]ctive range of motion of bilateral upper extremities is within functional limits." "Maximum lifting abilities are as follows: floor to knuckle, [Pt] was unable to lift an empty box from the floor to the knuckle due to inability to stand from a squat without upper extremity support. 12 inches to knuckle maximum effort of 38 pounds in 4 repetitions with limiting factor being poor body mechanics and decreased safety. Knuckle to shoulder was 43 pounds with limiting factor being decreased body mechanics as well as shortness of breath. Knuckle to overhead maximum effort of 33 pounds with limiting factor being decrease in safety and shortness of breath." Maximum pushing effort of 32 lbs and pulling effort of 72 lbs, averaging 3 trials. Maximum carrying effort of 33 lbs on right and left using unilateral carrier, although after 25 feet of carrying, pt demonstrated shortness of breath and decreased posture. Pt demonstrated no

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			difficulty with prolonged standing, walking, or changing from sitting to standing. Pt was able to climb 13 steps in 10 seconds, repeated 3 times for a total of 6 flights of steps, with limiting factor of shortness of breath and gradual decrease in posture. Grip strength of 62 lbs on right; 56 lbs on left; both are in 75th percentile for her age and gender. Palmer pinch strength of 16 lbs on right and 15 lbs on left, which is 90th percentile for her age and gender. Lateral pinch strength of 17 lbs on right and 16 lbs on left, which is about 90th percentile for her age and gender. Assessment: Pt "demonstrated poor confidence in her ability to complete tasks requiring encouragement to attempt tasks during the evaluation. Her maximum lifting abilities place her in the light work category. . . . [She] demonstrates significant amounts of deconditioning and [could] benefit from a work hardening program should she return to gainful employment."
03/15/01 R. 241-43	St. Anthony Regional Hospital Sheri Wanninger, PT	Physical Therapy Report - Disability Evaluation	Pt complains of constant pain in lumbar spine across her back; occasional pain in right hip into right upper leg and lateral hip; and pain from neck down to low back as the day wears on. Assessment, after examination: Pt's "range of motion and strength in her lower extremities did appear to be within very

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			functional limits. [She] does appear to be de-conditioned. She is having some lumbar discomfort, which is most likely due to her scoliosis. [She] is not doing any type of stretching or exercise for her low back at this time. [Pt's] gait is also limited due to her conditioning."
03/15/01 R. 268	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status stable and unchanged. Pt's blood pressure has improved since starting medication. Pt "continues to enjoy driving cab approximately 10 hours a week."
03/29/01 R. 267	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status unchanged. Discussed financial problems. Pt "is enjoying driving the cab and her boss is very understanding and helpful for her. She is contemplating another job but feels physically that she won't be able to do it for very many hours. She is considering options however." Pt is depressed but not suicidal.

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04/10/01 R. 244-51	J.D. Wilson, M.D.	Physical Residual Functional Capacity Assessment	Pt can lift/carry 20 lbs occasionally and 10 lbs frequently; stand/walk/sit, with normal breaks, for a total of 6 hrs in an 8-hr workday; no limitations on pushing, pulling. Pt occasionally can climb ramps, stairs, ladders, ropes, and scaffolds; balance, stoop, kneel, crouch and crawl. No limitation on ability to reach in all directions, handle (gross manipulation) and feel (skin receptors). Slight limitation in ability to finger (fine manipulation). No visual, communicative, or environmental limitations.
04/10/01 R. 252-53	J.D. Wilson, M.D.	Medical Consultant Review Summary	Pt's medically-determinable impairments are: "Levoscoliosis, lumbar spine, bilateral ulnar and median neuropathy with CTS, Level 1 obesity." None equals Listing criteria. Pt didn't complain of migraines to this consultant, and evidence doesn't support her complaints of migraines. "No reports of imaging studies of cervical spine are in file, & the only studies of low back were obtained with the [consultant], showing levoscoliosis. This would be expected to be affected somewhat by Level I obesity." No evidence of right shoulder tendinitis after 7/11/00. Pt's ulnar and median neuropathy are confirmed by EMG/NCV. Pt performs activities of daily living consistent with her pain complaints, although medical evidence

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			doesn't support her complaints. Pt says she could lift 20 lbs. Consultant found Dr. Motoc's opinions and recommendations re Pt's RFC "with marked restrictions of exertional, postural activities," were not supported by the evidence. He found Dr. Hardinger had simply reiterated Pt's "self-assessment of her capacity," which was not fully supported by the evidence.
04/13/01 R. 266	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status unchanged. Pt "is very positive, driving cab." Pt still thinks about suicide at times, but this is better and "she no longer thinks about 'taking her son with her'." Pt complains of more anxiety than depression. "She has an infection[] and just had minor surgery." Pt to "continue working and try to pick up the number of hours. She states that she feels good when working and that she usually enjoys it."
04/27/01 R. 265	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status unchanged. Pt feels "antsy," "can't sit still," and continues having mood swings. Says she feels this way often. Pt "continues to drive cab and is doing well with that." Pt "stays pretty busy."
05/09/01 R. 264	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	"Grooming, mood, and affect all improved." Pt "continues to drive cab which she likes," but she received two moving violations in the past two weeks. Pt agreed to attend women's depression group.

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05/17/01 R. 263	Carroll Regional Counseling Center Christine Carlson, LISW	Women's Depression Group	Pt arrived late for group, was not able to tell a funny story, and had little input. "She set a group goal of getting to know more people and to learn not to be serious about everything."
05/21/01 R. 262	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt failed to appear for scheduled appointment.
05/24/01 R. 261	Carroll Regional Counseling Center Christine Carlson, LISW	Women's Depression Group	Pt absent due to being in jail.
06/04/01 R. 316-19	Family & Specialty Medical Center, P.C. Steven J. Kraus, D.C.	Intake examination re head and neck pain following auto accident	Pt examined for complaints of head and neck pain and shoulder tightness following auto accident. Pain radiates down into right arm. Pt feel "off balance." Pt works at All American Cab as a cab driver. Pt reports being in pain 90% of the time. See radiology report.
06/04/01 R. 320	Family & Specialty Medical Center, P.C. Steven J. Kraus, D.C.	Radiology report	Cervical X-ray: cervical flexion and extension unremarkable. Film shows "hypolordotic spine with anterior weight bearing of skull on atlas"; "left list of the cervical spine with a right head tilt"; "right lateral malposition of C1 on C2 as well as rotational malposition of C1 left lateral mass anterior" "rotational malposition of spinous right at T1." Thoracic X-ray: adequate bone density for Pt's age. Thoracic scoliosis consisting of 15-degree "right convex rotatory scoliosis of the thoracic spine with apex present at the T7/T8 motion unit."

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06/05/01 R. 260	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt failed to appear for scheduled appointment.
06/06/01 R. 315	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Cervical pain, upper back pain, tight muscles and low back pain	Pt's back pain started last Saturday in MVA. Pt complains of "frontal headache, sharp neck pain, occasionally going up to a 9-10 our of 10 on the intensity scale." No radiation of pain into extremities; no weakness, numbness, tingling. Pt also complains of low back pain "with significant spasm upper and lower back." Assessment: Cervical strain, cervicalgia, headaches, muscle spasms, fibromyalgia, low back pain. Plan: Two weeks of physical therapy: "myofascial release treatments, electrical stimulation therapy and ultrasound treatments." Ultram for pain; Pt given samples of Skelaxin; return in 2 weeks.
06/11/01 R. 259	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Mental status: "Mood slightly depressed but pleasant and cooperative. Affect blunted. Eye contact poor. No suicidal ideation." Pt agreed to attend group on Thursday; scheduled follow-up in two weeks.

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06/13/01 R. 257-58	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check & treatment plan update	Pt is "still working driving a cab." She feels depressed, but not suicidal. Pt "has had some mood swings, irritability, temper and frustration but today she feels quite well." Pt doesn't meet criteria for "full blown bipolar I disorder but for a bipolar II disorder"; agreed to trial of Topamax when approved by patient assistance program. Current GAF of 61. Pt to continue counseling. Current medications: Effexor, Remeron, Celebrex, Ultram, Tylenol P.M. Pt to Return for medication check in 10-12 weeks, or sooner if Topamax is approved.
06/19/01 R. 314	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Follow-up re back pain	Physical therapy has improved neck pain; low back "still giving her significant problems." Some results with Ultram and Skelaxin. Driving exacerbates low back pain, but no radiation into lower extremities. Assessment: Persistent low back pain; cervical sprain, improving with present treatment; muscle spasm; myalgia. Physical therapy extended for two more weeks; Pt given samples Ultram and Skelaxin.

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06/25/01 R. 256	Carroll Regional Counseling Center Christine Carlson, LISW	Therapy session	Pt "was more depressed but cooperative. Grooming and dress deteriorated. She had fallen on the way to her apartment so was late. Affect blunted. Eye contact below average. No suicidal ideation." Pt reports being anxious and sleeping all the time. "She is working five hours per day now which is an improvement." Pt "agreed to start doing things to help herself keep busy so that she wouldn't be napping."
06/29/01 R. 307-13, 368	Family & Specialty Medical Center, P.C. Steven J. Kraus, D.C.	Chiropractic exam and physical therapy prescription	Pt complains of neck pain consisting of tight, dull ache; worsens with long periods of sitting. Pain is rated at 4 on scale of 10, and Pt reports moderate pain today. Pt complains of "a fair degree of difficulty in concentrating," and slight sleep disturbance. Prescribed physical therapy 2x/wk for 4 wks, then reassess. Diagnoses: Cervical spine and upper back pain, post injury. Deconditioned paraspinal and upper trapezius muscle.
06/29/01 R. 383-84	Family and Specialty Medical Center, P.C. Brian Bellinghausen, PTA	Physical therapy report	Tests show Pt has limited range of motion in flexion; below normal with lumbar range of motion. Cervical range of motion is above normal for 35 to 72 degree; below normal through the rest of the range.
07/11/01 P. 364-67	Family & Specialty Medical Center, P.C. Ryan P. Dodd, DPT	Physical therapy initial evaluation	Diagnoses: cervical sprain, low back pain, muscular weakness. Examination findings: moderate pain with palpation of cervical

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			and lumbar spine. Pt complains of pain in neck, back, right hip for some time, flared up after MVA. "Pain is constant in all areas." Increased neck pain when Pt turns head; increased back pain from sitting in car and lifting objects; increased hip pain with walking. Pt has moderate pain and limitation during and/or after specific activities of daily living, work activity, and recreational activity. Pt "gets pain with turning her head and sitting in the cab with work as well as with lifting objects. Limits her activities outside of work."
07/13/01 R. 363	Family & Specialty Medical Center, P.C. Ryan P. Dodd, DPT	Physical therapy progress note	No increased soreness since last visit. Pt has been working on her stretches. She "demonstrated good tolerance to new stairmaster activity but fatigued after only five minutes."
07/16/01 R. 362	Family & Specialty Medical Center, P.C. Ryan P. Dodd, DPT	Physical therapy progress note	Pt had no increased soreness from last visit. She has been doing stretches at home and work; home stretching program is going well. Pt bought a treadmill; not set up yet. In session, Pt completed the following exercises: treadmill 10 mins.; Stairmaster 7 mins.; Recumbent bike 10 mins.; "dynamic worked [sic] out on cervical extension MedX at 222 inch pounds for 20 repetitions"; "dynamic workout on lumbar extension MedX at 91 pounds for 17 repetitions"; stretches 10

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			mins.; upper and lower extremity isotonic exercises 20 mins.; dumbbell raises and lunges. "Pt was a little shaky on her lunges and could only kneel about half way down." Pt making good progress toward established goals.
07/18/01 R. 361	Family & Specialty Medical Center, P.C. Ryan P. Dodd, DPT	Physical therapy progress note	Pt reports the tops of her upper legs have been sore, but over all she is feeling good. She hasn't gotten her Stairmaster at home working yet, but has been walking and doing her stretches. Pt shown new lower abdominal exercises; she started to fatigue by 5 repetitions. Pt shown standing quad stretches, performed with no difficulty. "Pt is making good progress with all of her exercises and activities."
07/19/01 R. 305-06	Family & Specialty Medical Center, P.C. Steven J. Kraus, D.C.	Follow-up re neck pain	Pt rates pain at 1-2 on scale of 10, and reports intensity as "very mild." Pt opines she can lift very light weights; concentrate fully with only slight difficulty; do her usually work; drive and engage in all recreation activities with only mild neck pain. She is sleeping better.
07/23/01 R. 385	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy progress note	Pt continues to feel improvement in her neck and back. She is progressing in her MedX therapies.
07/25/01 R. 301-04	Family & Specialty Medical Center, P.C. Steven J. Kraus, D.C.	Follow-up re neck pain	Test results from strength tests; all appear to be improved over Pt's normal/baseline.

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07/25/01 R. 382, 385	Family and Specialty Medical Center, P.C Brian Bellinghausen, PTA	Physical therapy progress note	Pt worked a full day yesterday and her neck was stiff by end of day. Stretching helped loosen it up. Pt has increased strength and range of motion on MedX's, and is continuing to progress with all resistance activities. Pt to continue working out at rec center after completion of physical therapy.
07/25/01 R. 360	Family & Specialty Medical Center, P.C.	Extension of physical therapy treatment plan	Diagnosis: Cervical spine and upper back pain - post injury; Deconditioned paraspinal and upper trapezius muscle. Continue care plan 4 more weeks.
07/31/01 R. 345	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Mental status unchanged. Pt's work hours were cut to about 5 hrs/wk, due to possible closing of the company. Pt's "weight has shot up." Pt's mood is improved slightly but still "swings pretty fast."
07/31/01 R. 356-59	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy re-evaluation	Pt "has shown good progress with therapy, but continues to have pain and fall below norms on lumbar and cervical Med X." Continue therapy 2 times per week, 4 more weeks.
06/29/01 thru 07/31/01 R. 381	Family and Specialty Medical Center, P.C	Physical therapy training record	Record of physical therapy modalities completed by Pt for eight visits in four weeks.

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08/02/01 R. 343-44	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt is driving a taxi part-time. She expressed disappointment that her disability application was denied. Her speech was pressured, and she "continues to report temper and anger control problems, frustration, mood swings, irritability." She denies side effects from meds, and denies suicidal thoughts. Continue counseling sessions. Continue current meds: Effexor XR, Remeron, Celebrex, Ultram, Tylenol P.M.; plus Rx for Topamax. GAF 61.
08/02/01 R. 355	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy note	Pt cancelled appointment due to illness. (*See* R. 353)
08/05/01 R. 204	Herbert L. Notch, Ph.D. Clinical Psychologist	Psychiatric Review Technique	Dr. Notch reviewed the evidence and concurred in Dr. Wright's assessment of 02/26/01.
08/06/01 R. 354	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy note	Pt did not show up for scheduled appointment; caring for a sick child. (*See* R. 353)
08/08/01 R. 353	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy progress note	Pt reported holding sick 2-mo.-old child last few days "which really seems to have bothered her neck and shoulders." Low back is doing okay. Goal: progress Pt to independence w/weight training so she can continue at local rec. center; reevaluate Pt on MedX's.

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08/08/01 R. 380	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Physical therapy note	Brief discussion with Pt. She started on Topamax and reports no side effects. Pt is unable to afford Celebrex, which was effective for her in the past. Pt was given samples of Mobic.
08/10/01 R. 352	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy note	Pt cancelled today's physical therapy appointment.
08/13/01 R. 351	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy progress note.	Pt has been doing treadmill and stretches at home; reports overall improvement in back and neck, but she gets stiff "when she's in any one position for a long time." Pt's was unable to do repetitions on leg press due to leg fatigue; unable to kneel all the way down with step back lunges "demonstrating decreased strength in her [lower extremities]." Pt is now independent.
08/14/01 R. 341-42	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt failed to keep her appointment.
08/15/01 R. 350	Family and Specialty Medical Center, P.C Ryan Dodd, DPT	Physical therapy progress note.	"Pt reported her back still gives her trouble when she has to sit for long periods of time." Pt continues stretching exercises and walks on treadmill at home. Pt was unable to finish cardio workout because she had to go to work, but stated she would do treadmill at home.

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08/17/01 R. 323	Claude H. Koons, M.D.	Medical Consultant Review Comments	Dr. reviewed file and prior assessment of 4/10/01. Noted Pt was in MVA subsequent to that assessment "which allegedly aggravated her low back & neck. Seen later, the neck pain was improving, the back remained painful. An OT/PT functional evaluation not mentioned in the previous assessment dated 3/15/01 indicated [Pt] tested out as capable of "light work." The assessment of 4/10/01 concurred with that evaluation and continues to be appropriate."
08/21/01 R. 339-40	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt was recently placed on Topamax and lost 3 lbs in 2-3 weeks, but "only slight improvement in mood swings, irritability, temper and anger control and frustration." Pt sometimes doesn't want to go to work "because she is agoraphobic and doesn't want to be around people." No significant increase in depression, suicidal ideation, driving difficulties, or side effects from meds. Increase Topamax; continue meds and counseling.
08/22/01 R. 346-49; 370-79	Family and Specialty Medical Center, P.C Steven J. Kraus, D.C. Ryan Dodd, DPT	Physical therapy discharge summary	Pt re-evaluated on MedX's. Diagnosis: Cervical Sprain, strain; low back pain (postural). Pt "[c]ontinues to get pain with driving and other specific activities, but is not limited much by the pain." Pt reports that since Topamax was increased, she has less energy and "feels like she is in a haze."

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			She notes her pain is 90% to 95% better since she came to the clinic, with improvement in all symptoms. (*See* R. 370) Assessment: Pt "has made good progress with therapy. Slower progress the last 4 weeks; possibly due to medication change and affected energy level." Pt discharged from therapy, to continue exercise program on her own.
08/27/01 R. 338	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt cancelled appointment "late."
09/04/01 R. 337	Carroll Regional Counseling Center Christine Simmons, LISW	Intake update for counseling	Diagnoses: Axis I:" Bipolar Disorder; Panic Disorder with Agoraphobia; Major Depressive Disorder, severe, without suicidal ideation." Axis II: "Deferred." Axis III: "Carpal tunnel; arthritis; migraines; heart murmur; asthma; allergies to Codeine, Aspirin, Erythromycin." Axis IV: "Problems related to primary support group; social environment; financial and employment." Axis V: "Current GAF: 59."
09/18/01 R. 336	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt "reports no depression." Improved grooming and dress; good eye contact; improved memory. Pt was "chewing," which she stated is getting worse slowly since she started taking Effexor. Pt was "more alert"; stated she was tired so quit taking Topamax. Pt reports weird nightmares, not sleeping much. "She will be babysitting

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			and driving taxi." Pt expressed anxiety about terrorist events. Pt cautioned that she should not stop taking meds without talking to doctor. Pt still taking Effexor and Remeron.
10/02/01 R. 335	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt reports sleeping during the day, sleeping late into morning, and hardly sleeping at night. Therapist addressed Pt's "cognitive distortions about her inability to work (can't thinking, all or nothing thinking, over-generalization, and catastrophizing)." Pt agreed to think about possibility of working as desk clerk at hotel/motel, and baby sitting.
10/04/01 R. 333-34	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt stopped taking Topamax because she felt too sedated. She agreed to try Deseryl, and to try Trazodone to aid sleep. Pt states she is depressed but not as bad; denies suicidal ideation, driving problems, side effects from meds. Pt has financial problems. Therapist reports Pt is depressed and has low motivation to find a job. Pt was turned down for SSI a second time; is looking for an attorney.
10/15/01 R. 331-32	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt failed to appear for scheduled appointment.
10/22/01 R. 330	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt failed to appear for scheduled appointment.
10/26/01	Carroll Regional Counseling	Therapy session	Pt "was depressed and irritable

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R. 329	Center Christine Simmons, LISW		and fairly quiet." Poor eye contact. Pt is having financial problems. She is on her third try at SSD, is talking to a lawyer now, and reports "feeling overwhelmed and at times suicidal due to this." Pt "was finally able to look at some job possibilities but she was not able to build the necessary energy to do any more than that. She continues to feel that she must take care of and provide a home for her adult son who is not working." Pt "is deep into her negative thought patterns." Pt requested women's group.
11/08/01 R. 328	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt "was depressed but more cooperative"; continues to have financial problems. "Her hands are numb" and she is working only 5-10 hrs/week. Pt "is not exercising or getting to the Club House for anything." Pt's thinking is slightly more clear. Pt still requesting women's group but one isn't available.
11/20/01 R. 327	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt "was depressed but cooperative"; complains of memory problems, trouble thinking, not sleeping, and "weird dreams"; states sleeping pills are not helping. Pt's "belief system is pretty well entrenched. She believes she 'can't work' and so her finances keep getting worse and worse and her son isn't helping again but living there." Plan: "continue to chip away at her belief system."

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12/06/01 R. 326	Carroll Regional Counseling Center T.R. Liautaud, D.O.	Medication check	Pt doing somewhat better but still having financial difficulties. She is driving a cab, but hasn't been working much. She has done some babysitting, "but hasn't been paid yet. She reports that she is fairly stable." Pt "reports she is feeling somewhat better and enjoys working with [her counselor]." Pt is sleeping better. Current meds: Effexor XR, Remeron, Trazodone, and Ultram. GAF 63. Pt to continue present meds and counseling sessions.
12/11/01 R. 325	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt "was slightly less depressed." Pt excited that women's group is starting up again, but "shows very little progress otherwise."
01/03/02 R. 369	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Sinus pressure, headaches	Pt complains of sinus pressure, dysphagia, low grade fever, and frontal headaches. Assessment: 1. Acute sinusitis. 2. Dysphagia secondary to #1. Headaches secondary to #1. Pt started on Amoxicillin and Deconamine.
01/04/02 R. 324	Carroll Regional Counseling Center Christine Simmons, LISW	Therapy session	Pt is working 5-9 hrs/week; son is not working. Pt "stated that she and her son would like to buy a bar in Dedham and run it themselves. She has heard nothing from disability." Discussed steps toward buying and operating the bar, and Pt "was excited about something for the first time in a long time. She was thinking more clearly"; planned to talk bar's ex-owner about how to run the business.

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02/12/02 R. 386-88; 395-97	Family and Specialty Medical Center, P.C Brian Bellinghausen, PTA	Back and neck	Lift task exam. Arm lift - Maximum average 56 pounds. Not valid. Leg lift - Maximum average 57 pounds. Valid. Floor lift - Maximum average 65 pounds. Valid.
02/12/02 R. 390-91	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Functional capacity evaluation	Dr. treated Pt from June 1999 to June 2001, when Pt was "released from active therapy with home exercise instruction," and "[n]o ongoing prescribed treatment." She presents for functional capacity evaluation. (*See* R. 394) Pt can safely lift/carry 20 lbs occasionally; safely lift 33 lbs occasionally from floor level, 29 lbs from leg level, 42 lbs from arm level. Pt can lift/carry 10 lbs frequently; 16 lbs frequently from floor level, 14 lbs from leg level, 21 from arm level; all tests passed validity criteria. Pt can stand/ walk (with normal breaks) 6 hrs in an 8-hr workday, as long as she can pause 5-10 mins on an hourly basis. Pt can sit (with normal breaks) 6 hours in an 8 hour workday, but sitting should be limited to 45 mins at a time with 5-10 mins break afterwards. Pt is unlimited in her capacity to push/pull within the above restrictions; reported no fatigue or pain with pushing/ pulling simulation, 60 repetitions each. Dr. does not recommend Pt climb, stoop, kneel, crouch, or crawl up to 1/3 of the time, due to her low back pain and hip pain; how-

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			ever, she could do these activities "at least once/ hour." Pt has no limitation on reaching, handling (gross manipulation), feeling (skin receptors). Diagnoses: Chronic low back pain, Generalized anxiety disorder, Depression, Carpal tunnel syndrome. Pt could work in a job that accommodates her limitations, and could work 8 hrs/day with 5-10 min. rest every hour. Pt needs to take anti-inflammatory pain meds daily to control her chronic low back and hip pain. Dr. opined Pt could perform "better now than in November 2000."
02/12/02 R. 392-93	Carroll Regional Counseling Center John F. Wallace, Ph.D.	Psychological evaluation	Pt referred by her attorney for assessment of current intellectual capabilities. WAIS-III indicated Pt has Verbal IQ of 85, Performance IQ of 89, and Full IQ of 86. Pt had long response time for both correct and incorrect answers. Pt exhibited no general intellectual deficits, but did have a low Verbal Comprehension Index and low Processing Speed Index when compared with other indexes. Test results likely are valid estimates of her current intellectual functioning. Dr. concluded Pt "experiences particular problems associated with the comprehension of verbal material and the ability to process visual material rapidly," which could "constitute a predisposition to developing deficits asso-

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			ciated with reading, because reading requires the rapid and sequential processing of visual information." "With respect to work-related abilities, the deficit in processing speed would be expected to have an adverse impact in [Pt's] ability to maintain an appropriate work pace."
03/11/02 R. 394	Family & Specialty Medical Center, P.C. V. Ted Motoc, M.D.	Letter to ALJ	Dr. clarifies that his 02/12/02 recommendations were based on tests performed in his office that day, along with his clinical evaluation. Dr. stated: "The reason why I recommended a five to ten minutes break every fifty minutes is to allow more rest to her lumbar musculoskeletal system. These breaks can consist of alternative activities that would also provide the required rest to her back area. For example she may very well continue to work in a standing position for at least five to ten minutes after . . . prolonged sitting activities and vice versa."